Tabled
Hon N. Reed
June 11/87
Dr Elliott

NEW BRUNSWICK REGION 2

MENTAL HEALTH SERVICES DELIVERY STUDY

Report
December 1986

A report from

Woods Gordon
Management Consultants

A MEMBER OF ARTHUR YOUNG INTERNATIONAL

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December 18, 1986

Members of the Liaison Committee
Region 2 Mental Health Services
Delivery Study

Dear Sirs:

Re: Region 2 Mental Health Services Delivery Study

We are pleased to submit our final report for the Region 2 Mental Health Services Delivery Study. This report outlines our assessment of the current situation, recommends a new organizational model for the coordination and delivery of high quality mental health services, and provides a "ball park" estimate of the capital and operating cost savings of sharing selected services between the new facility and the Saint John Regional Hospital.

We have enjoyed working with the Liaison Committee, and will follow, with interest, your progress towards implementing the challenging new approach to mental health services described in this report.

Yours truly,

Woods Gordon

Woods Gordon

A. Backley

NEW BRUNSWICK REGION 2

MENTAL HEALTH SERVICES DELIVERY STUDY

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NEW BRUNSWICK REGION 2

MENTAL HEALTH SERVICES DELIVERY STUDY

EXECUTIVE SUMMARY

Following the decision to rebuild Centracare, a Liaison Committee composed of representatives from Centracare Saint John Inc., Saint John Regional Hospital and the Department of Health and Community Services was established to determine how the planning for a new facility might result in both better mental health services and greater cost-effectiveness.

The management consulting firm of Woods Gordon was commissioned by the Liaison Committee to undertake a two-phase study:

Phase 1 - To determine the most appropriate arrangement and organization of psychiatric services in Region 2 which will result in the optimum delivery of services within available resources.

Phase 2 - To identify and quantify the operational benefits of relocating Centracare to the Tucker Park Campus with some sort of physical connection to the Saint John Regional Hospital.

This report presents the results of this study, as approved by the Liaison Committee.

FINDINGS

An extensive interview and document review process identified eight major issues with regard to the organization and delivery of mental health services in Region 2:

1. Leadership

   - the absence of recognized leadership in regional planning, program development and program coordination, that is adequately in step with overall Departmental strategies

2. gaps in service

   - absence or underdevelopment of several key services including:

     - outpatient assessment and treatment
     - acute day hospital
     - child and adolescent psychiatry
     - day care programs
     - community-based support programs (vocational, recreational and residential) for chronic mentally ill patients
     - psychogeriatric assessment, treatment and continuing care

3. central assessment system

   - absence of effective intake mechanisms (for emergency and other patients) that ensure patients are routed to the most appropriate assessment and treatment services

4. continuity of care

   - absence of effective referral mechanisms (to the Clinic, family physicians, private psychiatrists, etc.) to ensure continuity of care for discharged patients

5. programming and continuing education

   - deficient multi-disciplinary programming and continuing professional education by all three major providers (Centracare, Saint John Regional Hospital and Regional Mental Health Clinic)

6. resource utilization

   - through lack of coordination, sub-optimal utilization of professional manpower resources and funding

7. advocacy and community relations

   - underdeveloped patient advocacy and community relations functions

8. education and research

   - underdeveloped education and research activities

Based on the experience in other jurisdictions, the general trends in mental health services across North America, and the unique circumstances in Region 2, the consulting team identified and assessed five optional organization models that could address the above issues, although

with varying degrees of success. The primary difference between the five models was the degree to which authority and responsibility was centralized in one body in one location.

RECOMMENDATIONS

The model referred to in this report as the "Saint John Institute of Psychiatry" was recommended by the consulting team as the most appropriate organizational approach for mental health services delivery in Region 2. The Liaison Committee, following review by the various interested parties, approved this recommendation in principle, and directed the consultants to proceed with estimation of the capital and operating cost savings associated with shared services on the Tucker Park Campus.

Under the recommended model, the Institute would become the sole provider of adult mental health treatment services (excluding medical office practice) in Region 2. It would also be responsible for providing tertiary inpatient care for Regions 1, 3 and 7. As part of its mandate, the Institute would be responsible for planning and coordinating long term psychiatric care for the elderly.

The Institute would be responsible for planning, developing and delivering all existing adult mental health assessment and treatment services (excluding medical office practice) and also the new services required to fill current gaps. It also would be responsible for continuing education, teaching, research and community relations functions.

A new Board of Directors would have to be established for the Institute, ideally drawing members from the two existing hospital boards as well as other community and patient advocacy representatives.

Centracare, with its current narrow service role, would disappear. Similarly, the Saint John Regional Hospital's role in providing adult inpatient psychiatric services would disappear (although it would retain its mandate for Child Psychiatry). Finally, the Regional Mental Health Clinic would relinquish its mandate for adult outpatient assessment/treatment, aftercare and day care services for psychiatric patients (estimated as 10-20% of its current caseload). The Regional Mental Health Clinic would continue to be responsible for psychosocial programming for adults and children (estimated as 80 to 90% of its current caseload).

Strong linkages would be required between the Institute and both the Saint John Regional Hospital and the Regional Mental Health Clinic to ensure coordination and cooperation in:

- cross-consultation for patients;
- geriatric program development;
- appropriate referral patterns; and
- continuation of a strong medical education program.

All provincial funding for the full range of services provided would flow directly from the Department to the Institute's Board of Directors. This funding might continue to be in two streams, one for institutional services and one for community-based programs, although one global budget (with clear performance requirements) would be preferable.

The majority of the assessment and treatment services would be located in the new Institute facilities on the Tucker Park Campus. However, for a few services (e.g., crisis intervention unit and some outpatient assessment, treatment and aftercare services) the Institute would use off-site space.

In addition to establishing the recommended organization model, there are a number of service improvements that should be undertaken. These improvements include strengthening current services, adding new services to fill gaps in the continuum, and enhancing intake and referral mechanisms.

IMPLEMENTATION

Although the new Institute facilities are unlikely to be ready for occupancy for another 3 to 5 years, there are many implementation steps which could, and should, be completed prior to the move to the new building. From this perspective, implementation can be broken into four phases:

- Immediate - implementation activities which can be undertaken immediately;
- Prior to the opening of new facility - implementation activities which can be completed over the next two or three years, prior to the opening of the new facility;
- One year after occupancy of the new facility - implementation activities which must wait until the new organization and programs have stabilized; and
- After opening of new facility - implementation activities which must wait until the new facility is available for occupancy.

ESTIMATED CAPITAL AND OPERATING COST SAVINGS FROM SHARED SERVICES

An analysis was conducted to assess the extent of benefits were the Institute to link in with the Saint John Regional Hospital and undertake some form of sharing/purchasing of services. The analysis assessed and compared benefits of sharing in comparison to the Institute, with its broad expanded mandate, not to the operations of the current, more narrow elements as at Centracare or Saint John Regional Hospital.

It is estimated that linking services to the greatest extent possible will have operating cost savings in the range of $1.5 million ± 20%, and capital cost savings in the range of $7.0 million ± 20%.

The actual savings achieved will depend on the decision made by the Institute and the Regional Hospital in the subsequent planning phases about the extent of sharing, the nature of the sharing and the effect this then has on the facility requirements (space, equipment).

SAINT JOHN - MENTAL HEALTH SERVICES DELIVERY

PROPOSED STUDY

I. PURPOSE:

1. To determine the most appropriate arrangement and organization of psychiatric services in Region II which will result in the optimum delivery of services within available resources.

2. To identify and quantify the operational benefits of relocating Centracare to the Tucker Park Campus with some sort of physical connection to the Saint John Regional Hospital.

II. SCOPE

1. Study excludes mental retardation

2. Psychiatric services includes community mental health services as well as hospital outpatient, day/night patient, inpatient and emergency services

3. Study will review the proposal that psychiatric services for children be provided in association with the Department of Paediatrics and the Regional Hospital, to assess feasibility of that proposal or suggest other alternatives.

4. The existing intern and resident training programs may not be weakened.

5. Studies which have already been completed on needs, services provided and by whom, bed requirements, will be consulted

III. ALTERNATIVES TO BE CONSIDERED

1. Present arrangement

2. Sole provider - i) Centracare
ii) Saint John Regional Hospital

3. Modifications to present arrangement

4. Other

IV. CLIENT

Centracare, Saint John Regional Hospital, Department of Health & Community Services, Liaison Committee

V. QUALIFICATIONS OF CONSULTANT

1. Previous successful completion of similar assignments

2. Objectivity and expertise in psychiatric services

VI. APPROACH

1. Study proposals will be solicited from appropriate consultant firms, reviewed by the Liaison Committee and a recommendation made to the Minister.

1. STUDY OBJECTIVES AND METHODOLOGY

1.1 STUDY OBJECTIVES

Woods Gordon was commissioned by the Liaison Committee[1] to fulfill two objectives:

Phase 1 - To determine the most appropriate arrangement and organization of psychiatric services in Region 2 which will result in the optimum delivery of services within available resources.

Phase 2 - To identify and quantify the operational benefits of relocating Centracare to the Tucker Park Campus with some sort of physical connection to the Saint John Regional Hospital

The Terms of Reference for the study are shown opposite. They specifically include community mental health services, while excluding mental retardation services.

Background

The impetus for the study came from the acceptance by the Centracare Board of Directors of consultants' reports[2] which recommended rebuilding Centracare (at 200 to 220 beds) on the Tucker Park Campus, adjacent to the Saint John Regional Hospital. As this strategy for providing new

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[1] Composed of representatives from:
- the Department of Health and Community Services;
- Centracare Saint John Inc.; and
- Saint John Regional Hospital.

[2] Functional Program, Centracare Saint John Inc., August 1984.

Evaluation of Alternative Site Locations, Centracare Saint John Inc., May 1985.

Centracare facilities included sharing selected "hotel" services with Saint John Regional Hospital, the two hospital boards agreed jointly to commission a study to assess the program improvements and economic savings that might be achieved through a shared site arrangement.

The Department of Health and Community Services was approached for its approval of the study. The Department requested an expansion of the study scope (to include community mental health services), joined the Liaison Committee and agreed to fund the study. Following issuance of the Terms of Reference for the study in March 1986, the Department purchased the site at Tucker Park Campus on behalf of Centracare. The Department also has provided written assurance to Centracare that its independent identity will be maintained on the new site.

Study Scope

The Phase 1 objective was to determine the most effective organizational arrangement for delivery of mental health services in Region 2. The Terms of Reference indicated that the consulting team should consult earlier studies that had been completed on needs, services provided and bed requirements. These previous "needs assessment" documents would provide the basis for examination of alternative organizational arrangements.

However, at the first meeting of the Working Group[3] on May 7, 1986, it was explained that not all of the necessary needs assessment work had been completed, and that some of the previous studies (most particularly the

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[3] The Working Group was composed of:
- the Executive Director and Medical Director of Centracare;
- the Executive Director and Chief of Psychiatry at Saint John Regional Hospital; and
- Department representatives.

Southern New Brunswick Mental Health Planning Study completed in March 1982) had not been entirely accepted by all parties. Woods Gordon agreed to assess the impact of the absence of the needs assessment information on the study and report back to the Liaison Committee on June 4.

The Liaison Committee meeting on June 4 made two decisions:

- o that the study should assume that Centracare will be rebuilt as a 200-220 bed facility on the Tucker Park Campus; and
- o that the Saint John Regional Hospital's Strategic Planning Task Force on Mental Health Services[4] should develop program capacity specifications for the following four service areas:
  - day/evening hospital programs,
  - outpatient assessment/treatment programs for patients with psychiatric problems,
  - psychogeriatric services (acute/assessment and rehabilitation), and
  - special care homes and other housing alternatives.

The Liaison Committee asked Woods Gordon to provide a facilitator to work with the Task Force on this assignment.

The enlargement of the study scope to include this needs assessment activity was documented in the Engagement Letter (dated May 13, 1986) and a follow-up letter (dated June 12, 1986), both of which are attached in Appendix A.

Following our meeting with Department officials on July 16, we received further clarification of the Department's understanding of the Terms of Reference for the study. This letter (dated July 23, 1986) also is attached in Appendix A. The main thrust of the letter is that the study

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[4] This task force is one of several established by the Saint John Regional Hospital to develop strategic plans for specific patient care areas. Its mandate is limited to its own hospitals's role, but the Task Force has included external representatives from Centracare and the Regional Mental Health Clinic to ensure a broader perspective on service delivery.

should focus on mental health treatment services, and should suggest delivery models which would assure that institutional care would have adequate linkages with other psychiatric care deliverers. The Department's understanding was that the study should not include review of the full range of community services in the mental health area.

The Phase 2 objective was to identify and quantify the operational benefits which might be achieved in the location of Tucker Park Campus for the new Institute building and building a physical link between the Institute and the Regional Hospital. The objective was not to develop a recommended set of linked/shared services but rather to assess the possible benefits, department-by-department, in order to provide both the institutions and the Department of Health with a broad 'menu' which can be used in further planning and negotiation.

1.2 STUDY METHODOLOGY

At the request of the Liaison Committee, the consulting team was expanded to include associates with relevant administrative and non-medical professional experience. The resulting team included the following individuals:

Phase 1

Alan Backley, Partner, Woods Gordon
Catherine Cornell, Principal, Woods Gordon
Colin Patey, Hospital Administrator
Ray Berry, Psychologist and Community Mental Health Consultant
Dr. N. Russell, Psychiatrist (long term care)
Dr. L. Frelick, Psychiatrist (acute care)

Phase 2

Alan Backley, Partner, Woods Gordon
Tannis Chefurka, Associate Senior Consultant, Woods Gordon
Jim Buchanan, Consulant, Woods Gordon
Steve Hudson, Senior Consultant, Woods Gordon

The methodology for Phase 1 of the study included the following activities:

- o review of a wide variety of existing documents and data received from both hospitals, the clinic and the Department;
- o an extensive interview program with:
  - Centracare management, psychiatrists and other professional staff,
  - Saint John Regional Hospital management, Chiefs of Psychiatry and Family Practice, and other professional staff,
  - the private psychiatrists practising in Saint John,
  - the Saint John Regional Hospital's Strategic Planning Task Force on Mental Health Services, and selected members of the Task Force on Geriatric Services,
  - Saint John Regional Mental Health Clinic management, psychiatrists and other professional staff,
  - members of the Saint John transfer team of the Centracare Community Placement Project,
  - Executive Director and Emergency Department physicians at St. Joseph's Hospital,
  - Dr. C. A. Roberts,
  - CMHA-Saint John president and staff, and
  - representatives of the Department of Health and Community Services;
- o briefing meetings with the Boards of Directors at Centracare and Saint John Regional Hospital;
- o weekly meetings with the Saint John Regional Hospital's Strategic Planning Task Force on Mental Health Services to facilitate their completion of specification of program capacity requirements in the four identified areas;
- o collection of information on mental health care models in other jurisdictions;
- o periodic meetings with the Working Group and Liaison Committee to review findings, conclusions and recommendations; and
- o production and review of a draft report for Phase 1.

The methodology for Phase 2 of the study included the following activities:

- o reviewing recent workload activity and financial data provided by Saint John Regional Hospital and Centracare;

- o review of the floor plans and other facility information provided by the two institutions;

- o review of previous planning studies relating both to rebuilding Centracare and to site options as to the considered locations, which included Tucker Park Campus;

- o developing and reviewing with the Liaison Committee the anticipated program elements and volumes for the Institute on which detailed benefits analysis was then based; and the identification of 17 departments to be studied;

- o interviews with senior staff at both the Regional and Centracare for those 17 departments;

- o discussions with senior staff at the Department of Health and Community Services, service agencies and equipment suppliers regarding current costs, appropriate organization/operation of services given current arrangements and/or experience elsewhere in New Brunswick; and

- o reviews of prepared material by the Executive Directors, the Department of Health and Community Services representatives and the Liaison Committee.

2. GOVERNMENT STRATEGY FOR MENTAL HEALTH SERVICES IN NEW BRUNSWICK

The delivery of mental health services has been undergoing a major evolution for the last three or four decades. This section of our report describes the general nature of this evolution in other jurisdictions and summarizes the changes that have been taking place in New Brunswick.

The purpose of this section is to demonstrate that the overall direction that the provincial government has taken is consistent with developments across North America.

2.1 EVOLUTION OF MENTAL HEALTH CARE

During the past thirty years, there has been a growing and strengthening development of community-based resources directed at providing mental health care alternatives that would reduce reliance on institutions. As far back as the 1920s and 1930s, mental health clinics (some of which travelled to outlying communities) were developed with the expectation that they would identify psychiatric problems in early stages of development in order to prevent more serious breakdown and to prevent hospitalization.

There have been important changes in all aspects of health care throughput the Western world (especially in North America) aimed at reducing reliance on inpatient care. These changes include the development of comprehensive outpatient services, day surgery and treatment programs, home care and, in New Brunswick, the establishment of the Extra-Mural Hospital program. The move to increase community-based mental health services is consistent with these developments. The rapidity with which change is

occurring, and the manner in which it is being effected, vary in different jurisdictions, but the thrust is the same -- to reduce dependance on institutional care.

Why Should Community-Based Programs Be Emphasized?

Evaluation of the effectiveness of different psychiatric rehabilitation approaches is complex, and relatively few rigorous studies have been conducted. Using two key indicators of success, recidivism[1] and post-hospital employment,[2] the following overall conclusions have been drawn from the evaluation research literature:

- a significant proportion of discharged patients are readmitted to hospital, regardless of the type of rehabilitation they receive. This appears unlikely to change as long as inpatient beds are available because hospitalization remains the treatment of choice for many patients, families and professionals.

- traditional methods of inpatient rehabilitation (individual or group therapy, work therapy and drug therapy) reduce symptoms and improve in-hospital behavior, but do not have an impact on functioning after discharge (as measured by recidivism and post-hospital employment).

- any of the non-traditional inpatient treatment methods (e.g., non-traditional group therapy, behavior therapy, token economy, attitude therapy, etc.) on their own do not appear to have greater long term success. Only a few, very comprehensive milieus (i.e., that combine several types of therapy approaches) have demonstrated an impact on functioning after discharge.

- aftercare clinics and other forms of moderate community support reduce recidivism, although the reasons are not clear, and the importance of patient motivation to attend has been demonstrated. Studies have shown that over half of psychiatric patients referred to aftercare clinics do not choose to attend, indicating the need for mechanisms to promote the use of these programs following discharge.

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[1] Recidivism is the percentage of discharged psychiatric patients who are subsequently readmitted.

[2] Post-hospital employment is the percentage of discharged patients who are competitively employed at time of follow-up or during the entire follow-up period.

- transitional facilities (e.g., half-way houses, sheltered workshops, day care facilities, etc.) are successful in reducing recidivism, but have shown little impact on independent functioning as measured by post-hospital employment. The patient appears to transfer his dependency from the hospital to the transitional facility.

- studies have demonstrated that non-professional volunteers can influence community functioning.

Based on the evaluation research literature, it would appear that there are three primary benefits from emphasizing community-based rehabilitation for mentally ill persons:

(1) aftercare clinics and other forms of moderate community support, if attended by the patient, appear to be successful in reducing recidivism;

(2) community-based programs cause less disruption and social stigma in patients' lives; and

(3) per diem costs of most community-based programs are lower than for inpatient programs.

Three Major Areas of Change in Mental Health Care

The changes in mental health care have been primarily directed at three areas:

- o development of alternative services to prevent institutional admission, particularly admission to psychiatric hospitals;

- o development of programs to enable discharge of patients who entered institutions in the past and have remained there many years; and

- o development of new approaches to coordination of services to ensure access and continuity of care.

(1) Prevention of Institutionalization

To reduce admissions to institutions, out-patient and community services have been established. For more seriously distressed patients who require hospitalization, there is a trend towards admission to psychiatric units in general hospitals, or a variety of day hospital programs.

Across Canada the provincial governments have created psychiatric units in general hospitals in an effort to integrate mental health services into the mainstream of general health care. The objectives were to remove some of the stigma of mental illness, to ensure appropriate physical as well as mental treatment, and to encourage shorter inpatient stays.

Many of the provinces also have funded the development of psychiatric outpatient and day hospital services in general hospitals, to allow a continuum of care to be provided by the same agency. The objective is to avoid admission, if possible, or at least to facilitate prompt discharge without the need to transfer the patient to another agency. Exceptions to this trend are British Columbia, Alberta and New Brunswick where separate community-based mental health clinics have been developed.

There also has been a recent trend towards the establishment of maximum-term (usually 72 hours) psychiatric assessment units. The objective of these units is to ensure that multi-disciplinary assessment is completed as quickly as possible, and that patients who can be treated on a day program or outpatient basis are not unnecessarily admitted (for which a 15-30 day stay is still typical). This development has emerged from reviews of patients' rights, rather than program evaluations.

The Day Hospital-Inn program in the Massachusetts Mental Health Centre is an example where inpatient hospitalization has been reduced even further.[3] In this program, all patients (after initial screening) are

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[3] Gudeman, J.E., Shore, M.F., Dickey, B., "Day Hospitalization and an Inn Instead of Inpatient Care for Psychiatric Patients", New England Journal of Medicine, 1983; 308:749-753.

Gudeman, J.E., Dickey, B., Evans, A., Shore, M.F., "Four-Year Assessment of a Day Hospital-Inn Program as an Alternative to Inpatient Hospitalization", American Journal of Psychiatry, 1985; 142:1330-3.

admitted to a day hospital program which serves as a focal point for diagnosis and treatment. Those who are too seriously ill to remain in this program are internally transferred to an intensive care unit. The day hospital physician and treatment team maintain responsibility for the patient while he is in the intensive care unit. The goal of the intensive care unit is to stabilize acute episodes of severe illness and return the patient to the day hospital (or the community) for definitive treatment on a day program or outpatient basis. As soon as the patient's behaviour is under control, and the patient can tolerate more normal social contact, the transition to the day hospital begins. The clear objective point of this program is to minimize dependence on inpatient hospitalization.

(2) Discharge of Chronic Patients

Programs also have been developed to reduce the number of persons with chronic psychiatric disorders who are living in large institutions. From the 1950s onward, the number of people in large institutions has been drastically reduced through:

- the differentiation between mentally ill, mentally retarded and senile patients, and the development of different care programs for each group;
- the use of chemotherapy;
- the establishment of behaviour modification, socialization, retraining and similar programs; and
- the creation of "half way" houses, community group homes, community day rehabilitation, activity programs, apartments, cooperative-living arrangements and other community support programs.

Not all service areas or jurisdictions have all the above programs in place, but the thrust throughout North America and Europe is clear and consistent.

In Canada, Saskatchewan led the way in discharging patients and reducing the supply of psychiatric hospital beds. No new admissions are occurring to these facilities. The other provinces have followed Saskatchewan's lead, but not all have been as successful in establishing alternative services.

All provinces have become involved, to varying degrees, in the funding of community-based support services (residential, vocational and recreational). However, for some patients this has meant little more than being transferred from the "back ward" of a psychiatric hospital to a smaller custodial facility -- often located in a rural setting to avoid community resistance.

Private not-for-profit and for-profit (residential) agencies have become very involved in this area of mental health care, using provincial funding provided through budgets or purchased service arrangements. The Canadian Mental Health Association has been active in encouraging the development of such agencies.

(3) Development of Coordination Mechanisms

As the variety of care methods has expanded, the need for coordination in planning and service delivery has increased in order to minimize duplication and service gaps, and to maximize the likelihood that patients will receive appropriate services on a timely basis.

Most communities, in Canada and elsewhere, have coordination problems. This is primarily due to four factors:

- absence of formal coordination mechanisms, or "solo provider" service structures;
- tensions between the different professional groups that have varying degrees of control in the different provider organizations;

- the common behavior patterns of many mentally ill patients (i.e., unreliability to continue medication, attend appointments or maintain stable employment and housing); and
- the need to preserve and protect individual freedoms in our society, which makes central patient registries less feasible.

A few communities have addressed the coordination problem by merging psychiatric and general hospitals (e.g., Owen Sound and probably North Bay in the future). This may resolve the coordination problem, but it also raises concerns about the adequacy of attention (resources) given to the psychiatric program within a full service hospital.

The general and psychiatric hospitals in Hamilton have addressed the coordination problem by establishing a single assessment unit (at one of the general hospitals) to which all patients must be referred for admission to any hospital-operated program. This approach ensures that all patients (including patients needing readmission) are properly assessed and referred regardless of any "labels" they may be carrying (e.g., former patient of hospital X). However, it also may mean a delay in admission or readmission.

Other communities (such as Kitchener-Waterloo) have developed central triage units using a multidisciplinary team, attached to the emergency department of a general hospital, to assess psychiatric patients in distress and refer them to appropriate services. This coordination mechanism, while less formal and mandatory than the Hamilton approach, has proven to be well accepted and valued by the health care providers in the area.

There are relatively few communities which have addressed the coordination problem effectively. The key factors appear to be leadership, good communication about respective roles and resources available, and widespread professional cooperation in ensuring that patients are

referred/accepted appropriately. As these factors cannot be easily commanded, effective coordination largely depends on consensus about goals and operating methods, and willingness to cooperate for the benefit of patients -- at the potential expense of professional and agency interests.

Need for Transitional Planning

For the evolution in mental health care to occur successfully, it is essential that the necessary alternative programs be developed parallel to the institutional system. Not all jurisdictions have been successful in establishing an adequate balance of institutional and community services. As a result, the shift of emphasis from institutions to community-based services has resulted in some patients becoming casualties of the change in treatment philosophy. Although this situation developed to some degree in some Canadian provinces, the primary examples are in selected American jurisdictions where deinstitutionalization has meant the neglect of the chronically mentally ill patient.[4]

In summary, the thrust of the changes which are occurring in New Brunswick is consistent with developments throughout North America. It is toward the creation of practical solutions to the complex transitional problems created by these changes that this study is directed.

2.2 NEW BRUNSWICK DIRECTIONS IN MENTAL HEALTH

New Brunswick has been interested in providing effective mental health services for many years, and was one of the first Canadian provinces to

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[4] Heseltine, G.F., Towards a Blueprint for Change: A Mental Health Policy and Program Perspective, December 1983.

establish mental health clinics. The provincial government has commissioned a number of mental health care planning studies over the last 15 years, including the Southern New Brunswick Mental Health Planning Study (March 1982) which assessed the mental health service needs of the Centracare catchment area. All of these studies have advanced the government's commitment to community-based programming, although none of them have been adopted fully as official government policy.

Over the last two years, a number of important documents have been prepared by the provincial government, among which are the following:

- Department of Health and Community Services, Report of the Planning Committee on Mental Health Services for Children and Adolescents, 1984;

- Department of Health and Community Services, Child and Adolescents: Mental Health Services, Working Paper, October 1985;

- Cabinet Secretariat, Action Plan for the Disabled in New Brunswick (October 21, 1985), which estimates the population in each disability category (e.g., 2.7% of the population or 18,500 people with mental illness) and provided the basis for the Premier's proclamation of "The Decade of Disabled Persons" on November 15, 1985. In this proclamation, the Premier emphasized the government's commitment to providing community-based support for all categories of disabled persons, including the mentally ill;

- Department of Health and Community Services, Mental Health Services in New Brunswick: Overview and Master Plan (December 1985) which outlines the Department's plans for four service sectors:

  - psychiatric hospitals,
  - psychiatric units in regional hospitals,
  - community mental health clinics, and
  - community-based services (including the Community Placement Project);

- Department of Health and Community Services, Centracare Community Placement Project: Information Statement and Sample Agreement with Residential Service Provider (February 1986) which outlines the goals, objectives and procedures for the Community Placement Project;

- Department of Health and Community Services, Mental Health Services: Procedures for Discharge Planning and Aftercare Services, undated;

- o Department of Health and Community Services, Secondary Prevention Guidelines, undated; and
- o Department of Health and Community Services, Safety Network System, Saint John Region (March 1986) which describes a proposal for the handling of crisis situations among long term psychiatric residents returned to the community.

The above documents reflect the Department's strategy for continuing the shift in emphasis from institutional to community-based mental health services. The Overview and Master Plan (December 1985) reaffirms not only the direction to be taken, but also the major issues to be resolved, and the priority areas for action. With specific reference to Centracare, this document indicates that priority has been placed on the redevelopment of Centracare as a 200-bed facility (adjacent to the Saint John Regional Hospital), and the possibility of the psychiatric hospitals providing acute care in Regions 2 and 5, through "an administrative arrangement with the regional hospitals". A copy of the Overview and Master Plan has been attached in Appendix B.

Some of the key planning decisions made by the provincial government over the past 15 years with regard to mental health care service delivery are:

- o endorsement and funding of acute psychiatric units in the regional hospitals for crisis intervention and inpatient treatment;
- o divestment of the two psychiatric hospitals to independent boards;
- o reconfirmation of the primary role of the regional mental health clinics in providing outpatient and aftercare services;
- o introduction of the Community Placement Project aimed at transferring long term residents from the two psychiatric hospitals to other settings (private homes, special care homes and nursing homes) in the community;

- o closing of the Roberts Children's Hospital School, with the residents returned to their own homes or group/foster homes, and to the regular school system; and
- o following amalgamation of the Departments of Health and Social Services, the decision to integrate selected community-based services (mental health, public health and personal social services) into one local delivery structure.

Level of Consensus

From our interviews and document review, it is clear that there are varying perspectives, within the Department and in Region 2, on how the provincial government's Master Plan for mental health services should be implemented. Different sectors of the system have different views on appropriate timing, resource allocations and roles.

In Region 2, Centracare appears to be the most cautious about the rate and nature of change, while the regional mental health clinic is the most enthusiastic. Both of these providers have been successful in retaining important program mandates. Centracare continues to operate its 60 acute care beds and has obtained approval for redevelopment as a 200-bed facility. The mental health clinic has retained its official mandate for outpatient and aftercare services, and resisted plans to have it relocated into the Saint John Regional Hospital. Meanwhile, the Saint John Regional Hospital appears to be having some success in obtaining Departmental approval to develop a Child and Adolescent Psychiatry Program.

However, two recent developments appear to question more directly the Department's overall strategic plan. First, Centracare's recently adopted Mission Statement and Delineation of Services identifies outpatient services (aftercare, day hospital, outreach and respite care) as an important part of the hospital's commitment to providing a continuum of

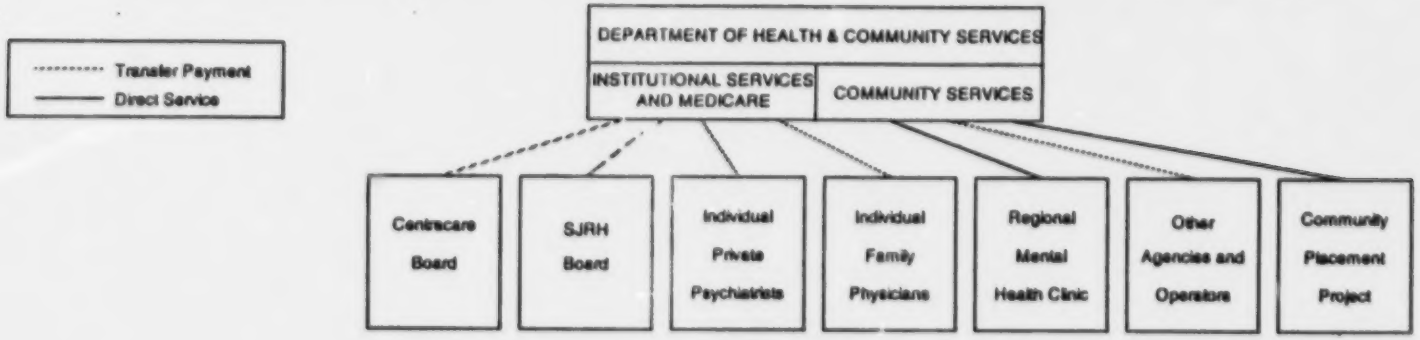
comprehensive psychiatric care. The Mission Statement builds on the hospital's informal provision of aftercare visits and industrial therapy day programming that has been available for selected patients in the past.

The second development is that the government has put the Community Placement Project on hold while a ministerial review is completed. This decision may be related to the slowness with which appropriate community-based services have developed, or the higher than expected residential costs for patients who have been discharged from Centracare.

These developments indicate that the timing of this study may be very appropriate for providing an independent assessment of the situation. Section 4 of this report presents our perception of the major issues to be resolved; Section 5 the principles that should be used in selecting an appropriate organizational model; and Section 6 the recommended organizational model for mental health services delivery in Region 2.

EXHIBIT 1

CURRENT ORGANIZATION OF MENTAL HEALTH SERVICES IN REGION 2



TREATMENT SERVICES	EMERGENCY		X	←	X			?
	INPATIENT:							
	– acute	X	X	←				
	– forensic	X						
	– rehabilitation	X						
	– Psychogeriatric assessment & treatment							
	– extended care	X						
	OUTPATIENT:							
	– assessment & treatment			X		X		
	– day hospital							
	– aftercare	X		X	X	X		X
	– day care	X				X		
SUPPORT SERVICES	SUPPORT:							
	– vocational						X	X
	– recreational						X	X
	– residential	X				→	X	X
EDUCATION			X					
RESEARCH								

JULY 15, 1988

3. CURRENT SERVICE PROVISION

The purpose of this section of the report is to provide an overview of the current provision of mental health services in Region 2. The order in which the various service organizations are discussed does not indicate relative importance in the system. Exhibit 1 illustrates the link between each organization and the Department of Health and Community Services, and the type of services each organization provides.

3.1 SAINT JOHN REGIONAL HOSPITAL

This large, modern, full-service teaching hospital provides service to the residents of Region 2. Located on the outskirts of the city adjacent to the University, it has excess plant capacity and vacant land nearby.

The hospital operates a 30-bed inpatient psychiatric teaching unit, with admitting privileges held by six fully qualified psychiatrists. (None of the psychiatric staff at Centracare or the Regional Mental Health Clinic have admitting privileges at the Regional Hospital.) The original plans for the hospital included a 60-bed unit, but the other 30 beds are being used for a hostel (primary for out-of-town radiotherapy patients). There are no outpatient psychiatric services, as the provincial government does not provide funding to hospitals for this purpose, and the hospital has not reallocated other funds to create such a program.

Within the last two years, plans had been made to relocate the Regional Mental Health Clinic from downtown to the regional hospital, and the necessary renovations to ambulatory space had been made, but the Department decided not to move the Clinic.

The hospital has been able to provide only limited allied professional resources to the inpatient psychiatric unit (e.g., a part-time social worker, limited psychology time and no occupational therapy). Furthermore, there are no trained psychiatric nurses on staff. As a result, the unit has a traditional medical approach to providing care, with little additional programming for the patients. (A good program would involve patients in activities for 75% of the daytime hours.) The average length of stay is 23 to 24 days which is a bit long, but not atypical from many other general hospital units.

In one year, the unit handles approximately 600 inpatient admissions which are concentrated in the affective disorders and depression diagnoses. The unit transfers a limited number of difficult-to-manage patients to Centracare, as it believes its facilities and staff are ill-equipped to handle such patients.

Information on the disposition of discharged patients is not readily available, but virtually all of these patients are followed-up by the private psychiatrists as part of their office practices in the community. The Regional Mental Health Clinic reported only 38 patients referred from all general hospitals in 1985.

The hospital's emergency department acts as the primary crisis unit for the region, with the emergency physicians using the psychiatrists on staff for consultations and/or referring the patients to other services (sometimes based on the patient's previous care provider). The hospital does not have a psychiatric triage unit or a short-stay psychiatric assessment unit.

St. Joseph's Hospital, by virtue of its downtown location, also must act as an unofficial crisis unit for mentally ill patients. The private

psychiatrists provide 24-hour consultation coverage for St. Joseph's, but admit patients only to the Regional Hospital.

The Regional Hospital's psychiatric unit has one resident and two interns, plus a rotating family practice resident. It currently undertakes little research. Only the Chief of Psychiatry is a GFT appointment with Dalhousie University.

There is no child or adolescent psychiatry program at the hospital, although a proposal (developed by the Strategic Planning Task Force on Mental Health Services) has been submitted to the Department. There is a perception in Saint John that the provincial government is showing some interest in this proposal. The program would require recruitment of a child psychiatrist.

3.2 CENTRACARE

Centracare Saint John Inc. is an old psychiatric hospital operated by an independent Board of Directors since 1978. It is located at some distance from both the downtown area and the regional hospital. Centracare has responsibility for providing specialized psychiatric inpatient care for the residents of Regions 1, 2, 3 and 7, and currently operates 364 beds:

	Beds
Forensic	17
Acute/admission	60
Rehabilitation	182
Extended Care	105

The daily census is over 300 patients, of whom approximately two-thirds are from Region 2.

Although Centracare does not have an official mandate from the Department to provide outpatient services (aftercare, day programs, outreach or respite care), it has identified these services as an essential component in the provision of an effective continuum of care. Informal aftercare and day program (industrial therapy) services have been provided for selected patients in the past, and the Board of Directors of the hospital has made a commitment to expand these services this fall.

Although Centracare has no emergency department, the nine psychiatrists on staff provide 24-hour on-call coverage to deal with emergency/urgent situations.

The forensic unit focuses specifically on assessments, with patients under Lieutenant Governor's Warrants admitted to the other psychiatric hospital in Campbellton.

Many of the admissions to Centracare's 60 acute care beds are readmissions, with a few new difficult-to-manage patients referred from the regional hospital. In 1985, approximately 630 patients were discharged from Centracare of which 75% were from the acute units, 17% from the forensic unit and the remaining 8% from the rehabilitation and extended care units.

Excluding the forensic patients, the 520 discharges were offset by 236 readmissions (45%). This 45% recidivism rate is not atypical of psychiatric hospitals. Of the readmissions, 28% were within the first 30 days following discharge. It appears that a relatively small number of patients (perhaps 50) account for the majority of readmissions. (Centracare is attempting to provide us with more specific information on this group of "revolving door" patients.)

Information on the disposition of discharged patients is not readily available. Some are referred back to their family physician, or a private psychiatrist, while others are referred to the Regional Mental Health Clinic, and a few are included in Centracare's own aftercare and day programs. In 1985, the Regional Mental Health Clinic reported intake of only 71 patients referred from Centracare. (Centracare is attempting to provide us with information on the number of patients refused to the Clinic during this time period.)

From a programming perspective, the psychiatrists direct the care on the acute units, but act only as consultants on the rehabilitation and extended care units. General practitioners on staff are the responsible physicians for these units. Although the hospital has reasonably well-staffed allied health discipline departments (e.g., psychology, rehabilitation therapies and social work), multi-disciplinary team functioning is still in development.

Centracare does not normally have psychiatric residents, and involvement in the training of other disciplines is limited. Although there is a research director on staff, the hospital's research activity is embryonic.

3.3 REGIONAL MENTAL HEALTH CLINIC

Established in the 1960s, the Regional Mental Health Clinic is a direct service of the Department of Health and Community Services for the residents of Region 2. It has the official mandate to provide outpatient services -- assessment, treatment and rehabilitation.

The main clinic location is in the city centre, adjacent to St. Joseph's Hospital. There are two sub-clinics (in Sussex and St. Stephen) and

one traveling clinic. All services are provided on a weekday 9-to-5 basis, with no on-call arrangements for off hours.

The Clinic has a multi-disciplinary staff including:

2 psychiatrists (plus two vacancies)
7 psychologists
6 social workers (one based at St. Stephen)
6 nurses (one based at each of the sub-clinics)
1 special education technician (i.e., occupational therapy)

The current Acting Director of the Clinic has a social work background. The Chief of Psychiatry at the regional hospital is acting as the Clinical Director (but is under the understanding that he supervises only the activities of the two psychiatrists).

The Clinic uses the primary therapist model, within a structure of three multi-disciplinary teams (child, adult and rehabilitation). Clients are assigned to individual staff for treatment, primarily one-on-one assessment and counselling on an appointment basis. Only a portion of the clients are seen by the psychiatrists.

The Clinic received referrals of 1,285 individuals in 1985, of which 52% were self/family referred and another 21% were referred by physicians. Only 9% were referred by the regional hospital or Centracare. This suggests that a large portion of the Clinic's caseload could be classified as psychosocial clients, rather than psychiatric patients.

The Clinic provides ongoing services to approximately 300 chronic psychiatric patients in the community. This group is not reflected for the most part in the referral statistics.

The Clinic does not provide assessment services for patients of other providers (e.g., the private psychiatrists or the regional hospital). Patients must be transferred to the Clinic's program to receive service. For patients that are referred, we understand that the Clinic does not routinely provide information back to the referral agency on the patient's progress, or investigate the reasons for "no show" if a referred patient does not keep the first or second appointment.

The Clinic reports substantial waiting lists for their services. Discharged Centracare patients are provided with two week's medication; therefore appointments are made at the Clinic two weeks from the date of discharge. Past efforts by the Clinic and Centracare to develop improved joint discharge planning procedures have met with little success.

The Clinic operates a 3-month Day Rehabilitation Program for 25 chronic psychiatric patients, many of whom have Centracare admission histories. Six of the places in this day program are reserved for residents of Centracare's half-way house at 285 Lancaster. The Clinic also operates a residential service for chronic patients (linking patients with available spaces in the special care homes in Region 2), and a vocational access program aimed at placing people in the regular job market, with on-the-job support and follow-up from the province's Vocational Rehabilitation Development Program.

One of the current staff vacancies at the Clinic is a child psychiatrist. The Clinic believes that this vacancy has had a major impact on their programming for children. We understand that the Clinic has a potential candidate who would be interested in a joint appointment with the Saint John Regional Hospital and has teaching interests. The joint appointment would be

a first step towards development of the Child and Adolescent Psychiatry program at the Regional Hospital, but additional funding would be required to build the remainder of the professional team for this program.

3.4 PRIVATE PSYCHIATRISTS

There currently are five fee-for-service psychiatrists practising in Saint John, all of whom have admitting privileges at the regional hospital and four of whom have faculty appointments. The five psychiatrists are located in one building, and coordinate the on-call coverage for the regional hospital and St. Joseph's Hospital. The group is attempting to recruit a sixth psychiatrist to share the workload and on-call responsibilities.

The private psychiatrists do not have any substantive interaction with the Centracare operations, although some of them used to be Centracare employees in the past.

In order to obtain assessment or treatment services by other disciplines (e.g., psychology),for their patients, they must admit them to the inpatient unit at the regional hospital, or arrange for them to see privately-practising professionals whose services are charged to the patient. Clinic services are available only if the psychiatrist relinquishes the patient to the Clinic. The types of patients referred to the Clinic tend to be those with "non-psychiatric" therapy needs (e.g., marital and family counselling), or chronic psychiatric patients who would benefit from the Day Rehabilitation Program.

The psychiatrists do not undertake any visits to areas outside Saint John, although they occasionally use public health nurses to make home visits on their behalf.

Based on estimates from the Southern New Brunswick Mental Health Planning Study (1982), the private psychiatrists provide care to approximately 2,700 patients each year. Of these, about 600 (22%) are admitted to the regional hospital. It is not known how many are referred to Centracare or the Mental Health Clinic.

3.5 COMMUNITY-BASED SERVICES

Region 2 does not have a well-developed infrastructure of community-based services to provide residential, vocational and recreational support for chronic mentally ill patients. The services that do exist tend to be focused on other non-psychiatric clients (e.g., the mentally retarded).

There are approximately 40 special care homes in Region 2, with 250 residents (of whom 70 are mentally retarded). The Clinic has a role in placement of mentally ill patients in the spaces that become available. Funding for special care homes is under the provincial social services mandate (i.e., income maintenance).

There is a general consensus that family physicians, who are often on the mental illness "front-line", have been inadequately involved in the continuing care of patients discharged from hospital.

The Community Placement Project was established as a direct service by the Department to facilitate the discharge of selected long term residents of the province's two psychiatric hospitals -- particularly those

with non-psychiatric diagnoses. Using a New York State assessment tool, Centracare staff identified approximately 100 long term patients who could be discharged to community settings.

The Saint John transfer team of the Centracare Community Placement Project has been active for almost two years. Sixteen patients have been placed in the community, and there are another nine patients in process. At the present time, the Project is on hold while a ministerial review is being conducted.

The Project focuses on identifying and providing each patient with the specific resources he/she needs to participate in normal community activities, rather than placing the patient in specialized programs (e.g., sheltered workshops or recreational groups, and group homes). Regular apartments and houses are found to house a maximum of three individuals, usually with live-in non-professional support. Participation in normal recreational opportunities is facilitated by use of volunteer "buddies".

For each patient, an Individual Service Plan is prepared (including estimated costs) and submitted to the Department for approval. A case manager assumes responsibility for ensuring that the service plan is implemented and up-dated as necessary. Now that the process has been established, the time frame for discharging a Centracare patient would average 90 days (including service planning, approval, and staff recruitment/training).

3.6 STATISTICAL OVERVIEW

There is no agency in Region 2 which is responsible for collecting statistics on the functioning of the total mental health care system.

The Saint John Regional Hospital's Strategic Planning Task Force on Mental Health Services (which includes representatives from Centracare, the Regional Mental Health Clinic, the CMHA-Saint John and privately practising physicians) played a valuable role in this study by collecting and interpreting data (on services and needs) from a variety of sources. This section of our report summarizes the information and conclusions from the Task Force meetings with regard to existing service patterns and unmet needs for specific programs.

Annual Volume of Patients Contacting System

Approximately 3,950 Region 2 residents are provided with mental health treatment services each year, or 2.3 percent of the population. This patient volume is distributed among the provider organizations as follows:

Private psychiatrists' office practice (no hospitalization)	2,300
Saint John Regional Hospital	600
Centracare	400
Regional Mental Health Clinic (no hospitalization)	650
	3,950

Of the 3,950 Region 2 patients using mental health services each year, approximately 1,000 are hospitalized:

Saint John Regional Hospital	600
Centracare:	
New admissions	150
Readmissions	50
Long stay patients	200
	1,000

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[1] Cabinet Secretariat, Action Plan for the Disabled in New Brunswick, October 21, 1985.

In addition to the 3,950 patients identified above, family physicians provide further service and, in any jurisdiction, some psychiatric cases will be admitted to medical units in general hospitals.

The provincial government has estimated that 2.7% of the population experiences some form of mental illness each year.[1] If this estimate is appropriate for Region 2, it appears that the current system is identifying and providing some service to most mentally ill residents.

Unmet Program Needs

The Mental Health and Geriatric Services Task Forces were asked by the Liaison Committee to assess the level of need for the following four programs:

- day/evening hospital;
- outpatient assessment/treatment;
- psychogeriatric assessment and treatment; and
- special care homes and other housing alternatives.

The conclusions of the Task Forces are presented below:

o Day Hospital (Acute)

  - Based on known patients, a total of 35 acute day hospital spaces are required. This would represent a potential reduction of 6,200 inpatient days (12 beds at Saint John Regional Hospital and 7 beds at Centracare).

o Day Care Programs (Rehabilitation and Maintenance)

  - A rehabilitation program would involve patients for 30 to 90 days, providing rehabilitation training, socialization and assistance to integrate into the community. The Regional Mental Health Clinic's Day Rehabilitation program (25 spaces) is an example of this type of day care program, but is serving too wide a client group and therefore has spaces blocked by maintenance patients. This size would be adequate if maintenance patients are excluded.

- A maintenance program would involve patients for more than 90 days and would be aimed at preventing readmission. Centracare's Industrial Therapy program is an example of this type of day care program. Another day care program is required, at a community site.

o Outpatient Assessment and Treatment

- Using California staffing guidelines, Region 2 requires 26 full-time-equivalent professionals (psychiatrists, psychologists, social workers, etc.) for adult outpatient services - excluding private practice psychiatrists. The Clinic now has 22 F.T.E. staff serving children, youth and adults. As children and youth account for 30% of the Clinic's caseload, the staffing available for adults is reduced from 22 to approximately 16 F.T.E.s, leaving a deficit of 10 F.T.E.s.

o Psychogeriatric Assessment and Treatment

- The Task Force on Geriatric Services has estimated that a 25-bed geriatric assessment and treatment unit is required for Region 2, with 100 nursing home beds allocated to psychogeriatric maintenance patients.

o Special Care Homes and Other Housing Alternatives

- During one year, approximately 100 chronic psychiatric patients have difficulty finding appropriate housing. This might be converted into a deficit of 33-50 spaces.

The Task Force identified the need for Child and Adolescent Psychiatry programs prior to the commencement of this study, and developed the proposal now before the Department.

In addition to these specific program requirements, the Task Force concluded that major problems exist in coordination of services. Therefore, a central assessment system and improved referral linkages should receive high priority.

4. MAJOR ISSUES

The purpose of this section of our report is to identify the major issues in mental health service delivery in Region 2 which should be addressed by our proposed model.

4.1 CONSTRAINTS ON CHANGE

The implementation of any major system change, such as the Department's Master Plan for mental health services delivery, always faces a number of substantive constraints which limit the speed and extent to which change can occur. The following constraints appear to be operative in this instance:

(1) shared responsibility for mental health services programming and funding between the Institutional and Community Services divisions of the Department;

(2) shared responsibility for planning and delivering mental health services among the various providers in Region 2;

(3) limited resources (both professional manpower and funding) to implement the Department's complete plan;

(4) underdeveloped infrastructure of non-treatment community-based programs (residential, vocational and recreational) for chronic psychiatric patients;

(5) absence of special purpose designed nursing homes for stabilized psychogeriatric patients;

(6) inadequate and unattractive facilities at both Centracare and the mental health clinic;

(7) fee schedule disincentives for certain types of treatment provided by the private psychiatrists (e.g., child psychiatry and psychogeriatrics);

(8) need to ensure reasonable access to services by region and by language; and

(9) presence of psychiatrists at Centracare and the regional mental health clinic who are not fully qualified as Canadian specialists.

The further development of mental health services in Region 2 must recognize and work within these constraints, at least for the next five to ten years. The last constraint (less than fully qualified psychiatrists) will be eliminated over time, as the new provincial licensing requirements will allow employment of only fully qualified psychiatrists in the future. However, this may result in an even further reduced supply of psychiatrists in Region 2. Psychiatrists have assessed the underlying problem, existing across Canada, as being under-production of psychiatrists by the medical schools and therefore a need to rely on foreign graduates.

It is our impression that the planning and introduction of the Community Placement Project failed to recognize adequately the importance of the constraints of resource limitations and underdevelopment of alternative services.

4.2 PROVINCIAL GOVERNMENT ISSUES

Although we have only partially completed our interviews with officials of the Department of Health and Community Services, we have identified the following issues which appear to be affecting the Department's success in introducing its Master Plan for mental health services delivery:

(1) fragmentation in service planning, funding and operations as a result of the policy decision to provide outpatient assessment, treatment and aftercare services through separate mental health clinics;

(2) incomplete communications and coordination between the Institutional and Community Services divisions of the Department, resulting in ambiguity in communications with organizations and individuals delivering care;

(3) uncertainty regarding the reorganization of the Community Services division (involving the integration of other community-based social services) and the effect this will have on the regional mental health clinics;

(4) uncertainty with regard to the continued implementation of the Community Placement Project for both Centracare and Restigouche patients; and

(5) incomplete success in communicating and selling its Master Plan to mental health service providers in the field, partly because important new roles have not been developed for some of the key players in the existing system.

The lack of clarity and consensus at the Department level has resulted in an apparent emphasis on who should deliver care, rather than on what care (programs) should be provided, and on how access and continuity can be assured. In other words, the efforts of the Community Services division in implementing the Master Plan have been perceived as focusing on reduction of institutional and medical influence on care delivery, rather than on ensuring timely access of patients to a full continuum of services.

Our assessment is that this perception has resulted from a combination of:

- ineffective Departmental communications to service providers in Region 2 with regard to its Master Plan strategy;
- premature implementation of the Community Placement Project given the relative absence of community-based residential, vocational and recreational support services;
- inadequate emphasis by the Department on the need for coordination of services and continuity of care for patients; and
- local coordination and communication inadequacies due to the absence of formal mechanisms (and informal commitment) that could bridge the compartmentalized services.

These issues at the Departmental level make it more difficult for local issues, discussed below, to be resolved.

4.3 REGION 2 - STRENGTHS

In our interviews and document review, we noted a number of strengths which will be important in improving mental health services delivery in Region 2:

(1) general consensus around the need for change in mental health care delivery, specifically:

- need for better coordination of services to improve access and continuity,
- need to avoid duplication of effort in order to maximize the impact of available resources,
- need for expanded outpatient and day hospital services, and
- need for a triage function for psychiatric patients in distress;

(2) strength of Centracare commitment to a major role in mental health care service delivery;

(3) informal communication links which have developed among the various service providers in Region 2:

- the Saint John Regional Hospital's Strategic Planning Task Force on Mental Health Services (which has been meeting on a biweekly basis for two years),
- informal liaison within individual professional disciplines (e.g., psychology) that cross organizational boundaries, and
- cross-appointments among the psychiatrists:
  - o appointment of the Chief of Psychiatry from the Saint John Regional Hospital as the Clinical Director at the regional mental health clinic,
  - o evening sessional work by two of the Centracare psychiatrists at the regional mental health clinic, and
  - o consultant cross-appointments between the regional hospital and St. Joseph's Hospital, and the regional hospital and Centracare;

(4) compared to other regions in New Brunswick, a larger number of psychiatrists, although the supply still remains deficient;

(5) the teaching program in psychiatry at the Saint John Regional Hospital, affiliated with Dalhousie University;

(6) strong consumer interest from the Saint John division of the Canadian Association of the Mentally Retarded, and growing involvement by the Saint John division of the Canadian Mental Health Association; and

(7) the opportunity to facilitate improved coordination, develop new programs and reduce the stigma of mental health services offered by the new Centracare facility.

The above strengths lead us to believe that the timing is right for consideration of new approaches to care delivery that would improve the access and continuity issues discussed in the next section, and maximize the impact of available resources.

4.4 REGION 2 - ISSUES

Our interviews and document review have convinced our team that there are a number of major issues related to mental health care delivery in Region 2. We also believe that there is general consensus among the various providers that these problems exist and that they must be resolved to improve patient care. The issues are:

(1) lack of full understanding of, and commitment to, the Department's Master Plan by all service providers in Region 2 -- particularly the policy decision that all outpatient assessment, treatment and aftercare services should be provided by the mental health clinic;

(2) failure of a strong leader to emerge in Region 2 to compel coordination in program planning and service delivery;

(3) fragmentation/compartmentalization of services, with inadequate coordination between services, resulting in major problems in:

- access to acute assessment and treatment services, and
- continuity of long term care and support services;

(4) absence of a sufficiently strong will, among the professionals working in the different organizations, to ensure continuity of patient care especially for discharged chronic patients;

(5) absence (or undercapacity) of some necessary services, particularly:

- outpatient assessment and treatment services,
- acute day hospital program,
- child and adolescent psychiatric services, and
- day care programs
- support programs for chronic mentally ill patients living in the community (residential, vocational and recreational);

(6) absence of effective intake and referral mechanisms that ensure that psychiatric patients (regardless of their socio-economic status or where they first enter the system) are routed to the most appropriate assessment and treatment services;

(7) deficient multi-disciplinary programming by all three providers (Centracare, Saint John Regional Hospital and Regional Mental Health Clinic), partly as the result of resource deficiencies;

(8) as emphasized in the Saint John Medical Society's report on the roles of the health facilities in Saint John, the absence of appropriate involvement of (and support for) family physicians in the continuing care of mentally ill patients;

(9) absence of planning and programs for psychogeriatric care, although the Saint John Regional Hospital's Strategic Planning Task Force on Geriatric Services is attempting to make progress in this area;

(10) underdeveloped programs of continuing education that would bring together multi-disciplinary service providers from the different agencies;

(11) underdeveloped teaching and research functions;

(12) underdevelopment of patient advocacy mechanisms for chronic mentally ill patients (as contrasted to the strong advocacy network for mentally retarded persons); and

(13) community resistance (or, at best, lack of readiness) to the transfer of Centracare patients to community settings, as evidenced by the reaction to the closing of the Roberts Children's Hospital School.

The model proposed for mental health care delivery in Region 2 must address these major issues, placing an emphasis on improving programs, access to acute assessment/treatment, and continuity of long term care and support.

5. ORGANIZATIONAL PRINCIPLES

The consulting team proposes the following set of organizational principles which should form the basis for structuring mental health services in any community:

(1) Leadership, competence and a strong commitment by all providers to work together on behalf of the patients are key elements of any mental health system, however structured. Major organizational problems, including substantial fragmentation of services, can be overcome if leadership, competence and commitment are sufficiently strong.

(2) All providers (both organizations and solo practitioners) must have a clear and accurate understanding of, and commitment to, the overall plan for the development and provision of services, and their respective roles in this plan.

(3) A continuum of services is required to meet the varying needs and preferences of patients, with appropriate linkages to ensure that patients can move smoothly between services as conditions change (i.e., continuity of care).

(4) To the extent affordable by society, appropriate programming should be provided for:

- children and adults; and
- mentally retarded, senile and mentally ill patients.

(5) The services obtained by an individual patient should be determined primarily by need and personal preference, not by socioeconomic status, referring agency or last provider.

(6) The system should avoid institutionalization whenever possible.

(7) The system should facilitate the admitted patient's return to normal functioning in the community as quickly as possible, both for the benefit of the patient (and family) and to make best use of available care resources. This necessitates the appropriate involvement of the family physician (and the family) in the care process.

(8) The system must ensure that all of the care requirements of patients are met (psychiatric, medical, emotional, vocational, recreational and residential). This necessitates appropriate involvement of different disciplines, and working relationships with support services not directly operated by the care system.

(9) As resources will always be limited, the system must ensure the best use of available resources, avoid duplication of effort, and ensure that all professionals and volunteers are involved in an appropriate manner.

(9) Emphasis must be placed on developing and maintaining high quality programming through:

- quality assurance, evaluation, peer review and audit activities;
- continuing education programs that bridge disciplines and agencies;
- involvement in teaching programs for all disciplines; and
- research activities.

There are a variety of organizational models which can be used effectively for mental health services. The needs, resources and culture of each community should influence the selection of a particular approach. Regardless of which model is selected, the key factors for successful implementation will continue to be leadership, good communication about respective roles and resources, and widespread professional cooperation in ensuring that patients obtain the services they require.

6. RECOMMENDED ORGANIZATIONAL MODEL

The government's decision to rebuild Centracare provides a unique opportunity for the Region 2 service providers to develop bold solutions to current service delivery problems. To simply rebuild Centracare without taking advantage of this rare opportunity would perpetuate the existing service deficiencies.

Agreement on major changes in service delivery and coordination will require strong commitment by all parties to optimal patient care. To the extent possible, agency interests will have to be set aside in an attempt to design an effective continuum of services that maximizes the use of professional manpower and funding.

6.1 OPTIONAL MODELS REVIEWED

The Region 2 issues discussed in Section 4 fall into eight main categories:

1) leadership

   - the absence of recognized leadership in regional planning, program development and program coordination, that is adequately in step with overall Departmental strategies

2) gaps in service

   - absence or underdevelopment of several key services including:

     - outpatient assessment and treatment
     - acute day hospital
     - child and adolescent psychiatry
     - day care programs
     - community-based support programs (vocational, recreational and residential) for chronic mentally ill patients
     - psychogeriatric assessment, treatment and continuing care

3) central assessment system

- absence of effective intake mechanisms (for emergency and other patients) that ensure patients are routed to the most appropriate assessment and treatment services

4) continuity of care

- absence of effective referral mechanisms (to the Clinic, family physicians, private psychiatrists, etc.) to ensure continuity of care for discharged patients

5) programming and continuing education

- deficient multi-disciplinary programming and continuing professional education by all three major providers (Centracare, Saint John Regional Hospital and Regional Mental Health Clinic)

6) resource utilization

- through lack of coordination, sub-optimal utilization of professional manpower resources and funding

7) advocacy and community relations

- underdeveloped patient advocacy and community relations functions

8) education and research

- underdeveloped education and research activities

Five Optional Models

Based on the experience in other jurisdictions, the general trends in mental health services across North America, and the unique circumstances in Region 2, our consulting team identified and assessed five optional organization models that could address the above objectives, although with varying degrees of success.

All five optional models had the following similarities:

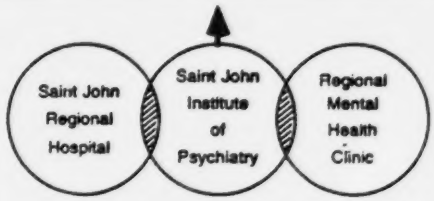
- they all assumed a new facility will be built on the Tucker Park Campus to replace the existing Centracare facility;

EXHIBIT 3

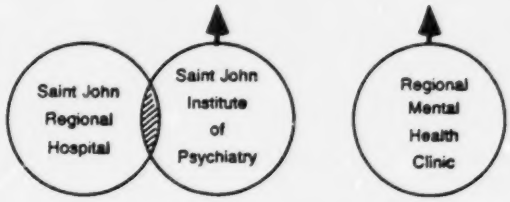
GRAPHIC ILLUSTRATION OF FIVE OPTIONAL MODELS

CURRENT SITUATION

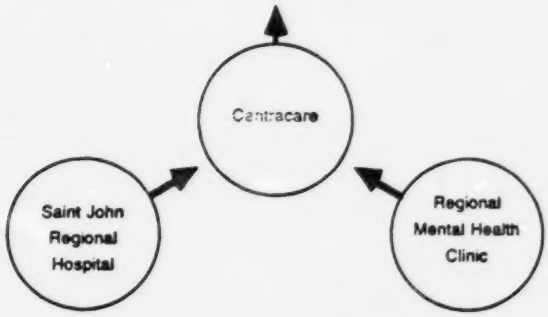
MODEL A
Saint John Institute of Psychiatry



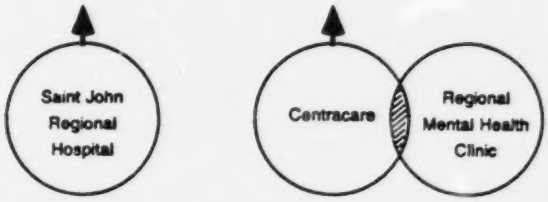
MODEL B
Saint John Institute of Psychiatry (Inpatient)



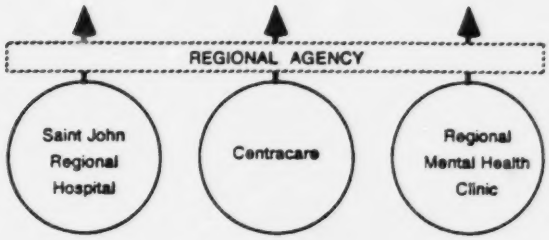
MODEL C
Centracare as Umbrella Management Board



MODEL D
Centracare with Expanded Services



MODEL E
Regional Planning and Coordination Agency



- they all focused on assessment and treatment services, with linkages to support services;
- they all included a multi-disciplinary central assessment system, referral linkage responsibility for discharged patients, and the filling of current gaps in service (see Section 6.3 for a discussion of the service improvements);
- they all included a continued (although sometimes diminished) service role for the existing provider agencies;
- they all provided some form of regional leadership for service planning, development and coordination; and
- they all aimed at increasing continuing education, teaching, research and community relations activities.

The primary difference between the five models was the degree to which authority and responsibility was centralized in one body and in one location. Model A concentrated more of the mental health treatment services in one facility than did Models B through E.

The five optional models were given the following titles for the purposes of this report:

Model A "Saint John Institute of Psychiatry"

Model B "Saint John Institute of Psychiatry (Inpatient)"

Model C Centracare as Umbrella Management Board

Model D Centracare with Expanded Services

Model E Regional Planning and Coordination Agency

Exhibit 3 provides a simplified illustration of the main differences between the five options.

EXHIBIT 4

RECOMMENDED ORGANIZATIONAL MODEL - "SAINT JOHN INSTITUTE OF PSYCHIATRY"

SERVICE/FUNCTION	RESPONSIBLE ORGANIZATION	LOCATION
PLANNING		
For mental health treatment (including psychogeriatric)	Institute	n/a
For psychosocial programs	Mental Health Clinic	n/a
For support services	Department	n/a
TREATMENT SERVICES		
EMERGENCY		
Medical care	Saint John Regional Hospital St. Joseph's Hospital	Saint John Regional Hospital St. Joseph's Hospital
Psychiatric care	Institute	Saint John Regional Hospital
CENTRAL ASSESSMENT		
72-hour unit	Institute	Institute
Outpatient	Institute	Institute
INPATIENT TREATMENT		
Acute	Institute	Institute and Saint John Regional Hospital
*Forensic	Institute	Institute
*Rehabilitation	Institute	Institute
*Psychogeriatric assessment and treatment	Institute	Institute
PSYCHOGERIATRIC EXTENDED CARE		
< 2 hours care/day	Nursing homes	Nursing homes
> 2 hours care/day	New facilities (including possible special nursing home)	New facility (including possible special nursing home)
Child Psychiatry	Saint John Regional Hospital	Saint John Regional Hospital
Adolescent Psychiatry	Institute	Institute
OUTPATIENT TREATMENT		
Psychiatric patients' treatment	Institute Private psychiatrists	Institute and Mental Health Clinic Private offices
Psychosocial clients' therapy	Mental Health Clinic	Mental Health Clinic and sub-clinics
Day Hospital (acute)	Institute	Institute
Aftercare follow-up	Institute Private Psychiatrists Family Physicians	Institute and Mental Health Clinic Private offices Private offices
Day Care (rehabilitation and maintenance)	Institute	Institute and Mental Health Clinic
SUPPORT SERVICES		
Linkage to services	Institute	Institute and Mental Health Clinic
Vocational services	Other providers	Other providers
Recreational services	Other providers	Other providers
Residential services	Other providers	Other providers
EDUCATION		
Professional training	Institute	Institute and Mental Health Clinic
Continuing education	Institute	Institute
*Outreach consultation	Institute	Nursing homes
Community relations	Institute	n/a
RESEARCH	Institute Mental Health Clinic	Institute Mental Health Clinic

* Services provided to Regions 1, 3 and 7, as well as Region 2.

6.2 RECOMMENDED MODEL

Model A, "Saint John Institute of Psychiatry", was recommended by our consulting team as the most appropriate organizational approach for mental health services delivery in Region 2. The Liaison Committee, following review by the various interested parties, approved this recommendation for further assessment in Phase 2.

Under the recommended model, a new entity (which for the purposes of this report was called "Saint John Institute of Psychiatry") would be established as the sole provider of adult mental health treatment services (excluding medical office practice) in Region 2. It would also be responsible for providing tertiary inpatient care for Regions 1, 3 and 7. As part of its mandate, the Institute would be responsible for planning and coordinating long term psychiatric care for the elderly, using lower levels of care as appropriate for patients beyond the acute assessment and treatment phases.

Organizational Implications

The Institute would be responsible for planning, developing and delivering all existing adult mental health assessment and treatment services (excluding medical office practise) and also the new services required to fill current gaps. It also would be responsible for continuing education, teaching, research and community relations functions. Exhibit 4 illustrates the Institute's range of responsibilities and the location of the various services.

A new Board of Directors would have to be established for the Institute, ideally drawing members from the two existing hospital boards as well as other community and patient advocacy representatives.

Centracare, in its current narrow service role, would disappear and its Board of Directors would be disbanded. Similarly, the Saint John Regional Hospital's role in providing adult inpatient psychiatric services would disappear (although it would retain its mandate for Child Psychiatry). Finally, the Regional Mental Health Clinic would relinquish its mandate for adult outpatient assessment/treatment, aftercare and day care services for psychiatric patients (estimated as 10-20% of its current caseload). The Regional Mental Health Clinic would continue to be responsible for psychosocial programming for adults and children (estimated as 80 to 90% of its current caseload). For a suggested methodology to differentiate between psychiatric patients and psychosocial clients, see Appendix C.

- Strong linkages would be required between the Institute and both the Saint John Regional Hospital and the Regional Mental Health Clinic to ensure:

  - o good medical care for psychiatric patients, and psychiatric consultation for Saint John Regional Hospital patients;
  - o cross-consultation and cooperative program development for geriatric patients;
  - o appropriate referrals between the Institute and the Regional Mental Health Clinic of patients requiring alternate care; and
  - o continuation of a strong medical education program.

All provincial funding for the full range of services provided would flow directly from the Department to the Institute's Board of Directors. This funding might continue to be in two streams, one for institutional services and one for community-based programs, although one global budget (with clear performance requirements) would be preferable.

Location of Services

The majority of the assessment and treatment services would be located in the new Institute facilities on the Tucker Park Campus. However, for a few services, the Institute would use off-site space:

- o a small proportion of psychiatric inpatients will require diagnostic services or treatment by other medical specialties that are appropriately provided only in an active treatment hospital setting (e.g., patients with anorexia nervosa). Approximately 20 beds will be required for these patients, located within the Saint John Regional Hospital, but organizationally and clinically part of the Institute's responsibilities. This 20-bed unit should be located proximally to the main building of the Institute.

- o the Central Assessment Unit's crisis intervention team would be based in the Saint John Regional Hospital adjacent to the Emergency Department;

- o some out-patient assessment and treatment services for Region 2 residents would be provided at the Regional Mental Health Clinic to accommodate patient preferences and encourage professional collaboration between the Institute and the Clinic;

- o similarly, some aftercare, day care and linkage with support services for discharged Region 2 patients would be provided at the Regional Mental Health Clinic; and

- o professional training programs would include exposure to community-based service provision at the Regional Mental Health Clinic, and research projects similarly would involve Clinic-based activities.

An arrangement would be required for the Institute to rent space at the Saint John Regional Hospital and the Regional Mental Health Clinic.

Impact on Psychiatrists and Medical Education

The recommended model would have a major impact on the Region 2 psychiatrists, as it would require the establishment of a single medical staff organization composed of the psychiatrists from the two hospitals and the Regional Mental Health Clinic.

This would not necessarily mean a single reimbursement system, as a combination of GFT, fee-for-service, sessional and salary arrangements would be possible. Given the current mix in qualifications, a combination model likely would be required, at least for the first few years. As the proportion of fully qualified psychiatrists increases, the variability in payment methods could be reduced. It is likely that establishment of the Institute would result in an increase in the number of GFT positions, and the number of fellows, residents, and clinical clerks.

One of the primary benefits of the recommended model is the potential for strengthening (and hopefully expanding) the medical education function by providing residents with a full range of experience. Nevertheless, the transfer of the medical education function to the Institute will require careful collaboration with Dalhousie University and the Saint John Regional Hospital.

The Institute should also be affiliated with Dalhousie University and the University of New Brunswick in relation to other professional training programs (e.g., psychiatric nursing, occupational therapy and social work).

6.3 SERVICE IMPROVEMENTS

In addition to establishing the recommended organizational model, there are a number of service improvements that should be undertaken. These improvements include strengthening current services, adding new services to fill gaps in the continuum, and enhancing intake and referral mechanisms. Each area of service improvement is discussed below.

Improved Programming

Our consulting team believes that the programmming should be improved at all three provider organizations:

- The psychiatric unit at the Saint John Regional Hospital is not providing appropriate multi-disciplinary programming, largely because it is under-resourced. Additional staff are required in psychiatric nursing, occupational therapy, psychology and social work. Good multi-disciplinary programming would help to reduce further the average length of stay, particularly in conjunction with the establishment of an acute day hospital (discussed below).

- Centracare requires further development of multi-disciplinary programming for both its inpatient and aftercare programs. The manpower resources appear to be adequate, but their potential is still under-realized because of the traditional approach to patient care.

- The Regional Mental Health Clinic's primary therapist model appears to have focused staff on scheduled one-on-one counselling rather than using a greater variety of therapy modes involving a mix of disciplines. Also, the Clinic does not appear to provide sufficient services to some of the chronic psychiatric patients who need continuing support to avoid readmission. This may be partially due to under-resourcing, particularly nursing.

In summary, all three provider organizations need to strengthen their multi-disciplinary approach to patient care and continuing education.

Central Assessment System

We endorse the conclusion of the Strategic Planning Task Force on Mental Health Services that a central assessment system should be established to ensure that patients are routed to the most appropriate assessment and treatment services. A three-part system is required:

- a multi-disciplinary crisis intervention team, located adjacent to the emergency department in the Saint John Regional Hospital, to deal with emergency cases;

- an outpatient assessment service to deal with non-emergent cases; and

- a 72-hour inpatient psychiatric assessment unit to ensure that multi-disciplinary assessment is completed as quickly as possible, and that patients who can be treated on a day hospital or outpatient basis are not admitted unnecessarily.

All three components should be part of one central assessment system, with the 72-hour assessment unit located in the new facility on the Tucker Park Campus.

Outpatient Assessment and Treatment

Because of the weekday service limitations, the Regional Mental Health Clinic's outpatient assessment and treatment services are not adequately responsive to urgent psychiatric cases in evening, night and weekend hours. Also, they are not adequately accessible to patients of other providers (this appears to be due to a need to ration available Clinic resources). As a result, some patients are admitted because they require prompt attention (even though they may not require 24-hour care), or in order to obtain psychological and other professional assessments.

Timely access of psychiatric patients to outpatient assessment and treatment services must be improved, either by providing these services in the new facility, or by changes to the Regional Mental Health Clinic's service policies and procedures.

Psychiatric On-Call Coverage

Region 2 is likely to continue to have a short supply of psychiatrists. Regardless of the organizational model selected, an on-call system that utilizes all of the available psychiatrists is necessary to meet the needs of the community in an efficient manner. Such a system also would

increase contact between the three groups of psychiatrists, and encourage sharing of programming concepts. A full joint appointment system would be the logical extreme of this sharing of emergency coverage responsibilities.

New Programs

To fill existing gaps in the service continuum, the following programs will need to be established:

- an acute day hospital for patients requiring more intensive treatment than an outpatient service can provide, but not requiring 24-hour care (estimated at 35 spaces);
- a Child Psychiatry service operated jointly by the Saint John Regional Hospital and the Regional Mental Health Clinic;
- an Adolescent Psychiatry service located in either the new facility or the Saint John Regional Hospital (depending on the organizational model selected);
- a psychogeriatric assessment and treatment unit located in the new facility; and
- additional day care spaces/programs for psychiatric rehabilitation and maintenance patients (focusing on the "revolving door" Centracare patients) located in the new facility and the Regional Mental Health Clinic.

All of these program gaps were identified in collaboration with the Strategic Planning Task Forces on Mental Health Services and Geriatric Services.

Improved Information Sharing and Referral Mechanisms

Currently, one patient sequentially may seek psychiatric service from both hospitals and the Regional Mental Heath Clinic without the different providers being aware of the duplication. This obviously wastes valuable professional time in completing three assessments. The central assessment system will help to address this problem.

Another major problem is that patients are referred between providers without adequate follow-up to ensure that the patient "arrived" and is receiving appropriate services. There also is little feedback to the referring agency on the patient's progress. Part of this problem is attitudinal - the various providers are not encouraged to ensure effective transfer of patient care responsibilities. However, it also is partially due to the absence of a central information base that would allow tracking of the reasonably small number of chronic psychiatric patients in Region 2.

Regardless of the organizational model chosen, the referral mechanisms must be strengthened and central information on chronic psychiatric patients must be made available to all the provider agencies. A micro computer system might be established in the new facility, with terminals in the Regional Mental Health Clinic and the Saint John Regional Hospital.

Aftercare Follow-Up for Patients Discharged from Centracare

Centracare's "revolving door" patients require continuity in their aftercare follow-up to reduce the frequency of readmission. We believe that Centracare should select those patients who require this type of service continuity, and operate its own aftercare and day care programs for these patients. The remaining discharged patients would be referred to the Regional Mental Health Clinic for aftercare and other services (e.g., linkage to residential, vocational and recreational services in the community).

Involvement of Family Physicians

General practitioners in the community are the "front line" for new and recurring psychiatric problems in any jurisdiction. We found that they are not being adequately involved in psychiatric patient care in Region 2, and are therefore ill-equipped to meet the needs of patients and their families.

The various provider organizations must be more active in adequately informing family physicians of their patients' treatment needs, and in developing continuing education mechanisms to reach this target group - particularly family physicians outside the Saint John area who carry much of the aftercare responsibility in their communities.

Strengthened Teaching and Research Functions

Involvement in teaching and research activities helps keep professional staff in all disciplines up-to-date and rigorous in their patient care activities. Also, teaching activities can help to attract future professionals once their training is completed.

For both these reasons, we believe that the mental health system in Region 2 should place a greater emphasis on teaching and research activities that can take full advantage of the complete spectrum of services provided and emphasize multi-disciplinary programming.

Special Purpose Designed Nursing Homes and Outreach Consultation

Centracare is an inappropriate setting for psychogeriatric maintenance (extended care) patients. Once the assessment and treatment phases are completed, these patients should be discharged to nursing homes

specially designed to manage psychogeriatric patients. Unfortunately, such places are in short supply in Region 2 (and most jurisdictions).

The Department should place priority on the development/renovation of such nursing homes in the future, to allow transfer of these patients, or the recommended psychogeriatric assessment and treatment unit will rapidly fill up with maintenance patients who cannot be discharged.

To reduce the demands on the psychogeriatric assessment and treatment unit, Centracare must provide outreach consultation to nursing homes to help them identify, intervene and manage the behaviour of deteriorating patients in order to avoid, or at least delay, admission to a higher level facility.

Community-Based Support Services

The Department must continue its efforts to develop more cost-effective community-based support services (residential, vocational and recreational) to avoid readmission of chronic psychiatric patients for non-medical reasons. These services should be available to all patients who require them, not just those identified for the Community Placement Project.

Community Relations

Once the organizational model has been selected, and an implementation plan developed, a community relations program must be designed to inform and convince the public that appropriate utilization of the full spectrum of services is the most effective long term strategy for mental health care. This community relations program also must explain how the

transition to the new model will occur, how employees will be assisted to play their role in the new organization, and how the community's security will be ensured.

6.4 IMPLEMENTATION

Although the new Institute facilities are unlikely to be ready for occupancy for another 3 to 5 years, there are many implementation steps which could, and should, be completed prior to the move to the new building. From this perspective, implementation can be broken into four phases:

- o Immediate - implementation activities which can be undertaken immediately, for example:
  - improvements in programming and continuing education;
  - establishment of a multi-disciplinary crisis intervention team, working with the emergency department at the Saint John Regional Hospital;
  - improvements in access to, and responsiveness of, the Regional Mental Health Clinic's outpatient assessment and treatment services to psychiatric patients;
  - involvement of all three groups of psychiatrists in a 24-hour coverage system for Saint John;
  - improvements in referral mechanisms;
  - increased aftercare and day care programming by Centracare for selected "revolving door" patients;
  - increased involvement of family physicians in aftercare and continuing education; and
  - development of outreach consultation to nursing homes.
- o Prior to the opening of new facility - implementation activities which can be completed over the next two or three years, prior to the opening of the new facility, for example:
  - planning for a psychogeriatric continuum of services, with particular emphasis on management of "anti-social" psychogeriatric patients;
  - improving the multi-disciplinary resources available to the inpatient unit at the Saint John Regional Hospital;
  - addition of the Child Psychiatry service operated jointly by the Saint John Regional Hospital and the Regional Mental Health Clinic;
  - development of a shared information system on chronic psychiatric patients;

- progress toward joint appointments of psychiatrists and involvement of Centracare in the medical education program;
- applied research initiatives;
- development of the implementation plan for the new organization model and an associated community relations program;
- establishment of the new Board of Directors and development of management policies and procedures, reporting relationships and job descriptions for the new organization/facility;
- planning for the new programs that will be included in the new facility (72-hour psychiatric assessment unit, acute day hospital, adolescent psychiatry, psychogeriatric assessment and treatment unit and additional day care programs);
- physical planning for the new facility;
- re-training of Centracare staff for their roles in the new facility; and
- planning for the disposal of the old Centracare site.

o <u>After opening of new facility</u> - implementation activities which must wait until the new facility is available for occupancy:

- initiation of the new programs located in the facility;
- implementation of a single medical staff organization; and
- disbanding of the Centracare Board of Directors.

o <u>One year after occupancy of the new facility</u> - implementation activities which must wait until the new organization and programs have stabilized, for example:

- re-assessment of the number of inpatient beds required, by program type, as a result of introduction of the 72-hour assessment unit, the day hospital and improved aftercare services.

7.0 BENEFITS OF LINKING HOSPITALS

7.1 THE SCENARIOS

Given the selection of Model A - the Saint John Institute of Psychiatry as the preferred approach to providing mental health services in Saint John, and given the proposal to build a new facility on the Tucker Park Campus to house the programs, a review was conducted to determine the extent of benefits and opportunities from linking the two facilities.

This analysis involved the review of seventeen departments which would be common to both Saint John Regional Hospital and the Institute of Psychiatry to determine what the benefits (financial, operational, professional) might be if sharing, contracting or linking were pursued.

The estimate of benefits achievable was compared to the future level of departmental resources were each department serving the clients and programs of the Institute from a service department based within the Institute (i.e, a freestanding, self-sufficient Institute of Psychiatry); in other words, a 'free-standing' versus a 'linked' scenario. The anticipated level of activity within the various program elements was defined early in the study phase to clearly direct the discussions and provide a basis on which the level of benefits could be established.

No attempt was made to identify which scenario would be preferable on a department-by-department basis. Ultimately, the decision on linking services will be based on one or a combination of factors:

- o obvious and significant financial benefits, either in operating costs (staffing, supplies, etc.) or capital costs (construction and equipment);

- o being able to at least maintain, and in some instances, improve the level or quality of service; and
- o the perception of the Institute as an autonomous institution, and whether sharing or linking for certain functions will jeopardize this significantly.

However, there are two premises which have been followed relating to the physical form and siting of the Institute. These are:

- o that there will be one consolidated location for all psychiatry program elements on the Tucker Park Campus; the only exception being approximately 20 acute psychiatry beds, which would be located in SJRH, as close as possible to the link between the buildings - these beds would be operated by the Institute in space leased from SJRH; and
- o that the Institute be a separate building, linked to SJRH, but located and massed in such a way as to provide an appropriate environment to the psychiatry patients (low-scale, access to the outdoors, etc.).

In addition, in reviewing the departments in detail to determine the benefits of linking, certain assumptions were made regarding the need for satellite locations and the manner in which services could be provided and the resources necessary to support them. In this way, an assessment could be made of the resources required (staff and space) and the benefits possible in a linked arrangement over a free-standing Institute.

The development of the base scenario (free standing) was drawn from a composite of information, including:

- o current Centracare information;
- o planning information from the 1984 Centracare Functional Program, where applicable;
- o resource levels which now support the SJRH component;
- o information collected from interviews;
- o floor plans for both Centracare and SJRH, where appropriate; and

- o information provided by outside sources/agencies such as the New Brunswick Department of Health, equipment suppliers, etc.

The information of the 'Linked' Scenario was developed in terms of additional requirements for those SJRH departments hosting a service; and for those where the Institute is host, the information was developed in terms of the savings in operating one integrated department instead of two. In this way, no staffing requirements are inferred for supporting SJRH's acute care service.

In determining additional staff requirements under the linked scenario where SJRH will be the host, we used, where appropriate, the SJRH computer-base workload measurement system indicators.

7.2 ANALYSIS OF SAVINGS AND BENEFITS

The term 'operational benefits', as used in the study's Terms of Reference has been interpreted more broadly than capital and operating cost benefits. In many department there are professional benefits which come with serving a broader range of clinical programs and patients. There is the potential for staff to become familiar with and competent in other specialty areas within their profession. In addition, this broader span of coverage can aid in attracting and retaining staff; it can also be more attractive to training institutions (Universities, Colleges) for student placements.

Obviously, such benefits cannot be quantified, but the extent of such benefits needs to be considered.

The methodology used in estimating the financial implications is as follows:

- o staffing costs: using approximate salary levels for the positions to be saved, plus 15% benefits costs;

- o supplies costs: in reviewing purchase costs by category for Centracare's past year, savings, due to consolidating the purchasing function, are likely to be achievable in only six categories: miscellaneous dietetic supplies; miscellaneous linen and sewing; housekeeping; business machines; printing, stationary and office supplies; and maintenance. In estimating savings through consolidation, the usual industry standard is 10%, although in this case, savings in areas such as maintenance will be higher, not due to consolidating purchasing, but due to relocating to a new building;

- o equipment costs: based on approximate current market costs in New Brunswick, information obtained from suppliers, hospital department heads or other senior staff;

- o construction costs: information has been obtained on current experience in the health care sector in New Brunswick - the cost being used is $160.00 per departmental gross square foot. This is based on the unit cost developed in consultation with the New Brunswick Department of Health and Community Services of $125.00 per square foot, factored up in order to reflect the cost per departmental gross square foot instead of cost per building gross square foot. Using d.g.s.f. allows a direct comparison of space needs and savings.

  While $160 per d.g.s.f. has been applied uniformly across all departments, in actual experience the costs for some areas will be higher, others lower.

7.3 CONCLUSION

In comparing the cost of constructing and operating a freestanding Institute of Psychiatry to the benefits and savings possible with sharing/linking with the Saint John Regional Hospital it appears that it will be possible to save:

- o operating costs of approximately $1.5 million ±20%, and

- o capital costs (construction and major equipment) of approximately $7.0 million ±20%.

The analysis which led to these conclusions has been provided to the Liaison Committee under separate cover in November 1986.

The savings ultimately achieved will depend on the discussions and negotiations between SJRH and the Institute, and selection of services to be linked and the nature this linking/sharing will take. This negotiation and selection will take place during subsequent phases of planning.

The review of information developed in Phase 2 did not alter the Liaison Committee's acceptance-in-principle of Model A - the Saint John Institute of Psychiatry.

APPENDIX A

ENGAGEMENT LETTERS

A MEMBER OF ARTHUR YOUNG INTERNATIONAL

Woods Gordon

Management Consultants
Suite 1209
One Brunswick Square
Saint John, N.B., Canada
E2L 4V1
Telephone: (506) 652-7360

May 13, 1986

Liaison Committee, Mental Health
Services Delivery Study
c/o Mr. G.W. Buchanan
Executive Director
Centracare Saint John Inc.
281 Lancaster Avenue
Saint John, New Brunswick
E2M 4H7

Dear Mr. Buchanan:

Engagement Letter

This letter will outline our understanding of our agreement with the Liaison Committee concerning the Mental Health Services Delivery Study. This understanding is based on our discussion with the sub-committee of the Liaison Committee on May 7, 1986.

Scope of Work

Our proposal to the Liaison Committee, dated April 9, 1986, outlined the activities we will undertake in completing the Mental Health Services Delivery Study.

At our meeting on May 7, the sub-committee explained to us that the Terms of Reference for the study (shown opposite page 2 in our proposal) were incomplete in two areas:

- Centracare responsibilities for providing services to the residents of Regions 1, 3 and 7 (as well as Region 2) were not referenced; and
- a definitive statement of the mental health services needs in Region 2 does not exist.

As our proposal was developed to meet the Terms of Reference, our workplan and budget do not allow for additional work in these areas. We have agreed to review the impact of this new information on the level of effort required to complete the study, and to report back to the Liaison Committee on June 4, 1986.

Membership of Project Team

At the request of the Liaison Committee, we have revised our study team composition to provide a better balance of professional perspectives. Our team will include:

Phase I

Alan Backley, Partner, Woods Gordon
Catherine Cornell, Principal, Woods Gordon
Colin Patey, hospital administrator
Ray Berry, psychologist and community mental health consultant
Dr. L. Frelick, psychiatrist (acute care)
Dr. N. Russell, psychiatrist (long term care)
Dr. A. Linton, medical consultant
Jim Buchanan, consultant, Woods Gordon

Phase II

Alan Backley, Partner, Woods Gordon
Tannis Chefurka, Associate Senior Consultant, Woods Gordon
Steve Hudson, Senior Consultant, Woods Gordon
Catherine Cornell, Principal, Woods Gordon

Mr. Keith Bowman, office managing partner in our firm's Saint John office, will be kept up-to-date on study progress to provide a local contact person for the Liaison Committee.

Timing

Our proposal outlined a total timeframe for the study of 20 to 24 weeks. We will do our best to complete the study in this timeframe, including the additional activity required at the front end to review the needs assessment issue.

Study Costs

We will complete the study activities outlined in our proposal for $65,200 in professional fees, plus expenses (estimated at $11,000 to 12,000). We will not exceed this fees quote without prior authorization by the Liaison Committee. Our estimate does not include the costs of any site visits to mental health programs in other jurisdictions, or any charges by the Saint John Regional Hospital's architects for work they may be required to undertake in Phase II.

It is our normal practice to invoice at the end of each month for the time spent on the project that month and the actual expenses incurred. These invoices will be submitted to you by our Saint John office, for forwarding to the Department of Health and Community Services.

We are very pleased to be working with the Liaison Committee on this challenging and innovative assignment.

Yours truly,

Alan Backley
Partner

AB:wm

A MEMBER OF ARTHUR YOUNG INTERNATIONAL

Woods Gordon

Management Consultants
P.O. Box 251
Royal Trust Tower
Toronto-Dominion Centre
Toronto, Canada M5K 1J7
Telephone (416) 864-1212
Telex 06-23191

June 12, 1986

Mr. G.W. Buchanan
Executive Director
Centracare Saint John Inc.
281 Lancaster Avenue
Saint John, New Brunswick
E2M 4H7

Dear Mr. Buchanan:

Re: Assessment of Needs for Non-Institutional Services

As directed by the Liaison Committee at our last meeting on June 4, our team met with the Chairman of the Saint John Regional Hospital's Mental Health Services Task Force yesterday to discuss the Task Force's ability to undertake the needs assessment work related to the following four non-institutional mental health services:

- day/evening hospital programs;
- outpatient assessment/treatment programs for patients with psychiatric problems;
- psychogeriatric services (acute/assessment and rehabilitation); and
- special care homes and other housing alternatives.

The Chairman agreed that the Task Force would be willing and able to undertake this assignment, with the following provisos:

- membership of the Task Force would need to be expanded to include a representative(s) from Community Services;

- for the purposes of this assignment, the enlarged Task Force should report to the Liaison Committee rather than the hospital's Board;

- that Woods Gordon should provide a facilitator to help keep the Task Force activities on schedule and to provide information on planning standards used in other jurisdictions; and

- that the psychogeriatrics issue will need to be referred to the Geriatrics Task Force.

Given these four provisos, the Task Force should be able to complete the work in four weeks. This will require moving from a bi-weekly to a weekly schedule of meetings.

We understand that the Task Force chairman will be contacting the Community Services representative(s) to invite him/her to join the Task Force.

Mr. Ray Berry from our team will act as the facilitator for the Task Force, as he has substantial experience in planning community mental health programs. Ray will rely heavily on Ms. Sue Johnson as the staff support to the Task Force.

Based on the foregoing, we estimate that an additional 6 to 8 days of Ray Berry's time will be required to work with the Task Force, interview Department officials in Fredericton and obtain planning standards from other jurisdictions. This translates into $5,500 to $7,500 in professional fees, plus expenses.

Please contact me immediately if you have any concerns or questions about this letter, as Ray Berry will begin working with the Task Force on June 17.

On behalf of the full team, I would like to express our appreciation to the staff of the two hospitals who were involved in arranging our schedule of meetings on June 10 and 11.

Yours truly,

Alan Backley
Partner

c.c. K. Tingley
S. Johnson

AB:wm

DEPARTMENT OF HEALTH
AND COMMUNITY SERVICES
P.O. BOX 5100
FREDERICTON, N.B., CANADA
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NEW BRUNSWICK
NOUVEAU-BRUNSWICK

MINISTÈRE DE LA SANTÉ
ET DES SERVICES COMMUNAUTAIRES
C.P. 5100
FREDERICTON, N.-B., CANADA
E3B 5G8

July 23, 1986

Mr. Alan Backley, Partner
Woods Gordon Management Consultants
P. O. Box 251, Royal Trust Tower
Toronto-Dominion Centre
TORONTO, Ontario
M5K 1J7

Dear Mr. Backley:

As a follow-up to our recent discussions with respect to the study of psychiatric service delivery in Region 2, I would like to clarify one or two points.

The terms of reference appear to be creating some confusion among the various involved groups. Item 2 under the heading SCOPE reads as follows:

> "Psychiatric services includes community mental health services as well as hospital outpatient, day/night patient, inpatient and emergency services".

I feel that inserting the word "treatment" after the words "mental health" might help to clarify this phrase, as this was intended to reflect the medical aspects of care.

The main thrust was for your firm to recommend some alternate models of delivery that would assure that institutional care, wherever it was delivered, would have adequate linkages with other psychiatric care deliverers, thus assuring that patient needs are met. The steering committee could then review your proposals, and from them make recommendations to the Minister.

I want to make it clear that your mandate does not include a study of the full range of community services in the mental health area, as this will be dealt with by our Department.

. . . /2

I hope this will help to avoid any misconceptions which may arise due to a previous lack of understanding in this matter, and allow your study to move forward.

Yours truly,

W. M. Allwood
Assistant Deputy Minister
Institutional Services & Medicare

APPENDIX B

Mental Health Services in New Brunswick:
Overview and Master Plan

Department of Health and Community Services
December 1985

I. INTRODUCTION

There are four components to the formal mental health system within the Department of Health and Community Services.

1. Two Psychiatric Hospitals

- Centracare Saint John Inc. - 364 beds
- Restigouche Hospital Centre - 478 beds

Global 1986-87 Budget : $36.0 M.

2. Psychiatric Units in Regional Hospitals

- Bathurst Regional Hospital - 20 beds
- Saint John Regional Hospital - 30 beds
- Hotel Dieu Hospital, Campbellton - 13 beds
- Moncton City Hospital - 27 beds
- Dr. Everett Chalmers Hospital, Fredericton - 30 beds
- Dr. Georges Dumont Hospital, Moncton 20 beds

Global 1986-87 Budget: $8.0 M. estimated
(psychiatric units are included in overall hospital budget)

3. Community Mental Health Clinics

- A major clinic in each of the seven health regions
- Sub-clinics and travelling clinics in 18 additional locations
- Average monthly caseload: 3,700
- Annual Contacts: 76,000

Global Budget 1986-87: $5.6 M.

4. Community-Based Services

- Providing community support services (residential, vocational, recreational)

Budget 1986-87:

- Residential	$3.6 M.*
- Vocational	$0.2 M.*
- Community Placement Project (Centracare/Restigouche)	$1.6 M.
- Children's Services Project (Wm. F. Roberts)	$0.1 M.

*Funded under Social Services Section

II. GENERAL DEVELOPMENTAL FRAMEWORK OF MENTAL HEALTH SYSTEM

- To establish a clear and sufficiently distinctive role for each of the components of the system (i.e.: the psychiatric hospitals, the community mental health clinics, the psychiatric units in the Regional Hospitals and community-based services).

- To shift primary focus for treatment and care to Regional Hospital psychiatric units and community-based services with specialized and rehabilitative care/treatment in the psychiatric hospitals.

- To develop appropriate links amongst the components of the system.

- To reducing unnecessary reliance on inappropriate long term hospitalization for those patients who can live in the community.

III. DETAILED COMPONENT DEVELOPMENT

1. PSYCHIATRIC HOSPITALS

Current Status

- Services a broad target base which overlaps with the Regional Hospital Psychiatric Units and the community Mental Health Clinics. Also are caring for a significant "non-psychiatric" population, more appropriate to residential care in the community.

Projected Role/Interface with Other System Components

- To provide specialized treatment and rehabilitative services for patients with medium to long term chronic and difficult to manage psychiatric problems.

- To serve as one of the major training and development resources for mental health services.

- Responsibility for special target groups such as long term involuntary patients, specialized forensic services and individuals remanded under a Lieutenant-Governor's Warrant.

- To serve as a "specialized" inpatient resource to the Psychiatric Units of the Regional Hospitals.

Issues (Major)

- Difficulty in attracting appropriately qualified staff (e.g. psychiatrists).
- Insufficient understanding of projected role.
- Continuing to care for large residual population who no longer need institutional psychiatric treatment and who should be cared for through the community components of the system.
- Personnel re-training and upgrading required per the Medicus study.
- Desire to retain a certain number of acute beds (in respect to retaining professional psychiatric staff).
- Site selection - new Centracare facility.
- Reducing hospital inpatient population to appropriate numbers and target groups.

Proposed Focus of Priority Activities

- Redevelopment of Centracare as a 200 bed facility (probably on site adjacent to the Saint John Regional Hospital).
- Determination of future size of Restigouche Hospital Centre. Possibly a 300 bed facility (per the recommendations of the Northern New Brunswick Planning Committee).
- Mechanism to be developed to control admissions to beds vacated through community placements.
- Possibility of Psychiatric Hospitals providing acute care in Regions 2 and 5 through an administrative arrangement with Regional Hospitals.
- Begin community placement of applicable Restigouche Hospital Centre patients.
- Cross appointments (institutional and community services) of senior clinical staff to ensure patient care continuity across the components of the system.

2. PSYCHIATRIC UNITS IN REGIONAL HOSPITALS

Current Status

- Provision of services mainly to the "voluntary" patient population.
- Do currently, in some instances, provide some outpatient aftercare services.

Projected Role/Interface with Other System Components

- To provide short term assessment, care and active treatment of voluntary patients.
- To provide assessment, care and active treatment of involuntary patients on a short term basis (i.e. up to 90 days).
- Provision of limited forensic services.
- To serve as the inpatient resource for the community components of the system.

Issues (Major)

- Staffing and physical plant capacity inappropriate for accommodation of involuntary patients.
- Child psychiatric services require development.
- Attracting appropriately qualified staff (e.g. psychiatrists).
- Need to protect budget components relating to psychiatric units within the hospital's overall (global) budget.
- Re-examining of the current distribution of the bed complements to ensure the psychiatric units have the capacity to meet new demands.

Proposed Focus of Priority Activities

- Ensure appropriate bed capacity and physical modifications in psychiatric units:
  - (a) in Edmundston and Campbellton, can be integrated within new construction;
  - (b) existing capacity in Saint John and Bathurst;

(c) in Moncton, little flexibility until expansion is completed;

(d) in Miramichi area, consider capacity in one or both of the hospitals.

- Focus on development of child psychiatric services collaterally with the Mental Health Clinics.

- Cross-appointments (institutional and community services) of senior clinical staff to ensure patient care continuity across the components of the system.

3. COMMUNITY MENTAL HEALTH CLINICS

Current Status

- Responding to an increasing broad based demand for general mental health services resulting in increasing waiting lists and inability to focus on high priority service needs.

Projected Role/Interface with Other System Components

- To provide assessment and treatment of pre-defined mental health problems on an outpatient community basis.

- Aftercare/follow-up of patients discharged from inpatient units in Psychiatric Hospitals and Regional Hospital Psychiatric Units.

- Provision of rehabilitative services to chronically mentally ill.

Issues (Major)

- Under-developed linkages between community Mental Health clinics and discharge units in inpatient psychiatric facilities.

- Lack of accessibility to services on a 24-hour basis.

- Clinics currently service about 1% of population, whereas they should be servicing about 3% requiring serious intervention (approximately 12% of the population require some type of mental health services).

- Demand on community Mental Health Clinics created through the Centracare/Restigouche Community Placement projects.

- Clinics are experiencing and will continue to experience volume increases as a result of:
  - the coming into force of the Young Offenders Act, Children's Services (William F. Roberts School).
  - need for geriatric assessment and care; demands of the public school system in terms of assessment, possible provision of services to forensic cases who are in correctional institutions.

Proposed Focus of Priority Activities

- Development of service priorities.
- Development of standards, program and funding guidelines and evaluation and monitoring systems.
- Cross-appointment of senior clinical staff to ensure patient care continuity across the components of the system.
- Increasing program capacity re:
  - severely handicapped children to replace William F. Roberts School/out-of-province residential services.
  - providing intensive aftercare/rehabilitation services to chronically ill patients discharged from Centracare/Restigouche.
  - geriatric population.
- Develop 24-hour service capacity linked with 24-hour emergency services at Regional Hospitals and Social Services.

4. COMMUNITY-BASED SERVICES

Current Status

- Under-developed and fragmented resources presently focused basically on non-psychiatric population.
- Under supply of psychiatrists playing a general practice role with an over supply of General Practitioners under-servicing psychiatric illness.

Projected Role/Interface with Other System Components

- Providing a range and mix of community support services (residential, vocational, recreational) for adults and severely disturbed children in order for them to be able to live in the community (rather than in the hospital).

- To increase the role of the General Practitioner in respect to general practice psychiatry and reinforcing the role of the psychiatrist in respect to specialty practice, consulting and teaching.

- To serve as a resource to the community Mental Health Clinics.

Issues (Major)

- Community support services system under-developed in Northern New Brunswick.

- Community-based staff not appropriately trained.

- Difficulty in attracting and retaining qualified psychiatrists.

- Report of the Northern New Brunswick Planning Committee has been presented to the Minister.

- Need for small residential treatment homes for emotionally disturbed children.

- Deinstitutionalization of Centracare patients has proven to be more expensive than originally forecasted.

- Organizational reform; difficult to comment at this time on integration and impact of social services component.

Proposed Focus of Priority of Activities

- Develop more cost effective residential alternatives for patients discharged from Centracare.

- Implementation of an already approved training strategy for community-based service providers.

- Identification of potential community service providers (residential, vocational and recreational) for Restigouche Hospital Centre discharged patients.

- Initiate Restigouche Community Placement Project.

- In cooperation with Social Services sector range of children's residential/treatment serv

- Improving recruitment strategy and retention for psychiatrists.

- Encouraging and enabling General Practiti provide more general practice psychiatric through training and sessional practice arrang

APPENDIX C

DIFFERENTIATION OF PSYCHIATRIC PATIENTS AND PSYCHOSOCIAL CLIENTS

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Arrival of a person at any mental health service requires the application of specific service principles:

1. Service will be provided based on the needs of the person referred.
2. Appropriate assessment and diagnostic procedures will be carried out to determine individual needs.
3. A treatment or service plan will be developed to meet needs in the most efficacious and appropriate manner, maintaining an acceptable quality of care.

A psychiatric disorder may be defined as a disorder of cognition, emotion or intelligence of sufficient severity to interfere with normal (the person's usual) function, or if left unattended, may lead to further breakdown at a later time. Those who have a psychiatric disorder may also require psychosocial services. Whether a case is designated "psychiatric" or "psychosocial" should not necessarily restrict the use of treatment resources to one or the other area.

Differentiation and decision about proper service placement will depend upon (1) general agreement among service providers about the intake procedure, and (2) a means to resolve differences of opinion when discrimination between a client or patient's conflicting needs is difficult.

1. There should be an intake procedure which allows for (and facilitates) necessary diagnostic assessment and referral to appropriate treatment services. All those who provide service within the system should have confidence that the procedure works to the benefit of patients, that appropriate referrals occur and that the decisions being made are clinically acceptable.
2. To avoid disagreement concerning the quality, appropriateness or efficacy of the intake procedure, a joint Clinical Review Committee must be appointed to establish acceptable intake procedures.

For the appropriate differentiation of patient care, both the Institute of Psychiatry and the Provincial Department of Health and Community Services must be accountable for the effective functioning of this Clinical Review Committee.

These and other clinic procedures should be subject to regular periodic review to determine that the policy with regard to clinic service is being carried out and that quality of care is being maintained. This would entail a systematic review of selected cases to check whether necessary action was taken regarding assessment, diagnosis, treatment and referral in order to assure that appropriate action is being taken on behalf of patients. This should be the responsibility of a specially designated clinic review team.

Such action should make it unnecessary to establish arbitrary criteria to differentiate psychiatric from psychosocial cases since the necessary discrimination will be made in the intake, assessment and referral process. Those patients whose problems are primarily psychosocial may be so designated and records kept concerning them if this is considered desirable.

If, upon admission, patients are to be directed to separate services, the Mental Health Clinic will have to establish a "triage" process based upon criteria established by Clinic staff to enable the staff making the decision to assign patients to the appropriate service. This will be difficult in the case of some patients who have both a psychiatric disorder and psychosocial needs. The criteria can only be established by the Clinic staff and it will be necessary to apply continuous checks to determine that it is working effectively.